United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

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I. Background

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

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

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

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

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

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 the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.
(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

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 addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement.

This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;

(c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;

(d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

(g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

IV. Substantial Compliance Ratings and Progress

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

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

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

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

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

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

V. Executive Summary

As always, the Monitoring Team appreciated the willingness of staff at Corpus Christi State Supported Living Center (CCSSLC) to share information and their time. Progress continued to be made in important areas. However, a number of the concerns that remained continued to impact individuals' health and wellbeing. It is essential that over the coming months priority be placed on resolving these outstanding areas. This should be possible given that a number of key positions have been filled, and staff clearly are committed to the improvement process.

One of the areas of concern continued to be with the healthcare and clinical supports provided to individuals with medical as well as physical and nutritional support needs. This was an example of a support system that required the attention and integrated efforts of many staff at the Facility, including clinical staff as well as direct support professionals and their supervisors. In order to address these outstanding concerns, the Facility needed to better utilize the information it had available to identify and correct deficiencies. As illustrated below, this information was available through a number of sources. However, the Facility was not yet using the information to make the needed changes.

In 2012, 14 individuals had died. It was not the Monitoring Team's role to complete a full analysis of the deaths, and the Monitoring Team did not attempt to conduct such a review. However, in reviewing some of the most recent deaths, the Monitoring Team identified a number of issues and trends that the Facility either had not identified itself, or, when it had identified them, had not acted to correct them in a timely manner. Some of the concerns identified included:

- Death reviews were problematic. There was often not a critical review of information leading to recommendations aimed at making systemic improvement. Another major concern was the lack of follow-up to recommendations from the administrative death reviews. Some of the recommendations had system implications, but these were not addressed through action plans and monitored until completion. Some of the problems with this process included:
    - Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. Based on a review of eight deaths for which the Facility had conducted mortality reviews since the Monitoring Team's last visit, the administrative death reviews included a total of 15 recommendations. However, there were additional clinical death reviews with recommendations that were not reflected in administrative death review recommendations. The rationale for not including them in the administrative death review recommendations was not clear, as there were no minutes of the content of discussion at these meetings.
    - With regard to follow-up on the recommendations, there was only one recommendation with a partial follow-up response to a recommendation. This was a focused in-service, but did not lead to any systemic change in policy/procedure or monitoring policy/procedure to ensure changes had been made. This response was inadequate for the systemic needs of the Facility. For the other 14 recommendations, there was no follow-up information available.
    - In addition, death reviews did not identify the full array of issues that required further investigation and/or action. Some that the Monitoring Team identified included the potential need for further discussion about whether or the Facility's two respiratory therapy positions were adequate to meet individuals' needs, in-depth and historical review to determine whether gastroesophageal reflux disease (GERD) was treated optimally at an earlier stage in prior years, the lack of interdisciplinary (IDT)

meetings to discuss and plan for individuals who had been hospitalized, and the lack of nursing care plans in place for significant conditions.

- The cause of one death was choking. Given ongoing risk for individuals at the Facility, it was not clear that Facility staff understood the need to act to correct existing deficiencies. Although the Monitoring Team did not complete a full analysis of all choking incidents, the following very concerning incidents showed a trend that the Facility had not addressed in any meaningful way:
  - Of significant concern, one individual had orders for a nothing by mouth (NPO) status, but on 3/25/13, was observed to be coughing up Fritos. The Integrated Clinical Services Review Team requested an ISPA response by the IDT by 4/1/13, which did not occur during the week of the Monitoring Team's observation of morning meetings.
  - Individual #46 had a choking episode when the individual attempted to swallow an entire chicken breast whole. This led to partial airway obstruction, hospitalization, and ventilator support. During his two-week hospital stay, the chicken was found lodged in his esophagus and was pushed through to the stomach. He recovered. A follow-up swallow study indicated no problems, and he continued to eat a regular diet. He had several events approximately four months later. He tried to eat chicken along with the chicken bone, and the IDT determined the kitchen would debone the chicken prior to serving it. It was reported he ordered pizza by himself, without staff support, then ate it. For a short time after the choking incident he was on one-to-one staffing during meals, but that was discontinued. The team believed increased supervision would escalate behavior and that one-to-one supervision at all times was not justified. As of October 2012, he was placed on routine supervision at all times. That he is sufficiently independent to order pizza makes this a challenging situation, along with the behavioral issues. However, when focusing on the risk of choking, he had a severe choking episode requiring two weeks of hospitalization. Not all documents were available, but no information was found concerning whether he would benefit from a smaller snack between meals, whether his unsafe and rapid eating had predictors, and whether the housemates made his risk worse. However, his risk remained high, and there were no current steps to monitor him closely during meals or other actions to reduce his risk, despite his life-threatening event this past year.
  - Individual #297 had an order to receive nothing by mouth, but swallowed chicken with bones, drank coffee, and swallowed an egg at different times within one week. No ISPA was submitted during that week or the following to indicate the team reviewed these concerns and made further action plans to reduce these high-risk behaviors.
- Moreover, as is discussed with regard to Section O, the Monitoring Team along with Facility therapists observed numerous staff failing to implement individuals' physical and nutritional support plans (PNMPs), including their dining plans. These plans were designed to reduce to the extent possible individuals' risks during mealtimes as well as at other times when swallowing difficulties could pose a risk. Despite a choking death, as well as

numerous other incidents in which individuals choked or obtained access to food when they should not have, the Facility had not put comprehensive measures in place to reduce these risks.

- Based on a review of eight deaths that had occurred since the Monitoring Team's last review, six of eight individuals (75%) had prior hospitalizations within 12 months prior to death. Four of eight (50%) had been hospitalized previously within four months of death.

The State had agreed that hospitalizations would be critically reviewed. This was essential, because a full analysis of what was contributing to deaths had to start before people died, and steps needed to be taken to reduce hospitalizations to the extent possible. However, as discussed in further detail with regard to Section G.1 as well as Section M.1, during the six months prior to the Monitoring Team's review, there had been 48 hospitalizations. In addition to only a limited number of reviews being completed, essentially no appreciable action was taken to address individual or systemic issues identified. More specifically, in August 2012, a Hospital Prevention Health Monitoring Tool was developed to assist in identifying issues that might have prevented an individual's hospitalization. The Program Compliance Monitor (PCM) completed the audit for at least three individuals who required hospitalization. The Hospitalization Prevention Committee, which had been established in August 2012, initially discussed the findings. Although the minutes of the committee meetings included some very promising findings and action plans addressing problematic issues, most of the completion dates were left blank and thus, it could not be determined if recommendations for system changes were actually implemented. In addition, the committee was dissolved in November 2012, and the findings of the Hospital Prevention Health Monitoring Tool were to be discussed during the individual's Individual Support Plan Addenda (ISPA) meeting. However, the documentation contained in the Presentation Book for Section M.1 indicated that the Facility needed to continue to work with teams in incorporating this information into the ISPAs. No information was provided regarding how this process was being addressed or what positive outcomes, if any had been achieved. Consequently, it was unclear to the Monitoring Team if this promising process was still in place at the time of the review.

However, review of the one review of a hospitalization showed it identified serious issues, many of which the Monitoring Team has repeatedly found and reported on with regard to the provision of nursing care (i.e., Section M). More specifically, this report identified problems with nursing staff not performing appropriate assessments as dictated by the affected and related system(s); monitoring the individual's health care status sufficient to readily identify changes in status; creating/modifying a nursing care plan as needed to address changes in the individual's condition; implementing a nursing care plan as needed to address changes in the individual's condition; after an actual or potential acute illness/injury, closely monitoring the individual; and/or communicating to all direct support staff and oncoming nursing staff their monitoring and follow-up responsibilities. In its analysis of deaths, the Facility did not seem to understand the importance of taking into

consideration data coming from other sources, such as this review, when considering the systemic fixes necessary to address the underlying issues. As discussed with regard to Section M, the Facility had not made improvements in these areas, and no plan was apparent for addressing these critical issues. In addition, CCSSLC's Integrated Clinical Services Team (i.e., morning meetings) was not asking critical questions about individuals who had been hospitalized, and/or developing plans to prevent hospitalizations.

As this summary indicates, in order to resolve the issues relate to the provision of healthcare supports to individuals, the Facility needed to make many improvements. These improvements required a coordinated approach, and needed to involve at a minimum the Medical Department, the Nursing Department, Habilitation Therapies, the Integrated Clinical Services Committee, Residential Services, the Qualified Developmental Disabilities Department, and individuals' IDTs. The improvements were needed most importantly to improve the lives of and reduce the risks for individuals the Facility served, but also to comply with the Settlement Agreement.

The following is a brief summary of Corpus Christi's status with regard to specific sections of the Settlement Agreement:

Restraints

- The Monitoring Team noted significant progress in the management of the use of restraints, including:
  - New forms for restraint reporting had been implemented and automated;
  - The Debriefing Reviews by Behavioral Services were documenting information with the potential to expand the understanding of the circumstances that precede behaviors that lead to restraint;
  - Electronic forms were in use and had improved the quality of the forms such as the legibility of the entries.
  - The Restrictive Practices Committee appeared to have settled into a productive meeting process that was based on data and served to focus attention on reducing the use of restraints and other restrictive practices. Under new Facility policy, the committee was meeting three times each week and reviewed both restraint use, trends in use, and levels of supervision; and
  - The Facility's Avatar data system was again producing restraint data and trend reports on use of restraints. Data reports had been developed which allowed data on restraints to be arranged in a variety of ways to facilitate analysis.
- Some areas were identified that need attention, including:
  - Adjustments were needed to restraint documentation forms processing to assure that dates of reviews are documented on the forms;
  - The Restrictive Practices Committee should continue to work to achieve good attendance at meetings and to document discussions and decisions in the meeting notes;

- While much progress was noted, more work was needed to assure that the psychologists who complete the Debriefing forms gather information on circumstances prior to the development of restraint-necessitating behaviors, and include it in their reviews, when such information is not present on the Restraint Checklist or the Face-to-Face sheet; and
- While additional restraint monitors were trained, there should be clarity in the training and in practice that the restraint monitor should not be the person applying the restraint.

Abuse, Neglect and Incident Management

- Progress was noted in a number of areas. Highlights of that progress included:
  - The Facility's use of supervisory forms for reviewing UIRs and sending them back to investigators for correction appeared to be in consistent use and demonstrating results;
  - New posters for alerting individuals to their rights and staff to the need to prevent abuse were in place; and
  - The annual ISP planning meeting for an individual during the week of the site visit included a discussion of incidents over the past year.
- Some of the areas in which improvements were necessary for the Facility to progress towards substantial compliance with the Settlement Agreement included the need to:
  - Address the problem with timeliness of completion of Unusual Incident Reports;
  - Develop and implement a semi-annual audit of injuries;
  - Provide for follow-up on recommendations from investigative reports, and document them to conclusion, including a check to assure that the desired outcome has been achieved;
  - Expand the analysis and trending of data to determine where corrective action plans might be needed to address emerging trends in abuse/neglect findings; and
  - Resume the use of the Section D monitoring tool in cooperation with the Quality Assurance team or adopt a new one. This joint monitoring effort will help to assure that the details needed to meet and sustain compliance are objectively reviewed and assessed.

Quality Assurance

- Since the Monitoring Team's last review, the Facility had made some progress with regard to Section E, including:
  - Changes in the assignments of Program Monitors to sections to bring fresh eyes to various sections of Settlement Agreement monitoring;
  - A data inventory was available, providing a useful tool to quality assurance and the disciplines;
  - There was an increase in the number of Corrective Action Plans (CAPs);
  - The Quality Assurance/Quality Improvement (QA/QI) Council adopted a new schedule for reviewing the performance of each section; and

- Several workgroups had been established by the QA/QI Council to address specific concerns and to complete CAPs where indicated.

- Some of the areas that will need to continue to improve for the Facility to progress towards substantial compliance with the Settlement Agreement included:
  - It was not clear how the data generated by the Quality Assurance (QA) Monitoring tools would be used in preparation of the Facility Self-Assessment. The source and reliability of data used in the self-assessment needs to be identified in order to be helpful in determining if the Facility is in substantial compliance;
  - Not all sections had a QA monitoring tool and were using it. Some sections were using tools that they indicated needed changes to be useful. It will be important to adopt and use tools that provide meaningful data that in aggregate will allow decisions to be made about system change and about how to identify and support individuals with substantial issues;
  - Work was needed on the QA Plan narrative to include its purpose and to append the Matrix and the Data Inventory;
  - The Facility needs to produce a list of CAPs that are based on data analysis, include measurable outcomes, and are designed to make important changes; and
  - Departments and disciplines need to identify key indicators of performance and monitor progress.

<u>Integrated Protections, Services, Treatments and Supports</u>

- After participating in training from DADS State Office in October 2012 and January 2013, CCSSLC teams began using the Individual Support Plan (ISP) Preparation Meeting format, revised ISP template, revised Integrated Risk Rating form, and Integrated Health Care Plan format. At the time of the Monitoring Team's review, the Facility was still in the initial phases of implementing some of these forms and processes, and CCSSLC had not had the benefit of the more extensive training that two Facilities currently were undergoing. However, some improvements were noted, and Facility staff were able to identify some of the other areas in which deficits existed.
- Timeliness as well as quality of assessments, and team attendance at ISP meetings continued to be areas on which the Facility was working to make improvements. The QA/QI Council was regularly reviewing timeliness and attendance data. Some discipline heads were reviewing some assessments for quality. However, this was in the initial stages of development and implementation.
- With regard to individuals' ISPs, although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals' needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. The Facility recently had begun to use the Integrated Health Care format, which expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences.

- Although action plans included more measurable action steps, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome.
- The Facility had adopted a new monthly report format. It was positive that the newest format included graphs to provide more information about individuals' ongoing process with skill acquisition programs. However, because the ISP action plans did not include many of the healthcare and other clinical supports the individual was provided, the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy.
- The Facility had made progress with regard to its quality assurance system related to the ISP process. The QA Department and the QDDP Coordinator had continued to work together to revise the tool they used to monitor ISP meetings, as well as ISP documents. They were working on establishing inter-rater reliability, including modification of review tools and the related instructions. Efforts were in the initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development. The QA/QI Council was regularly reviewing some components of the data.

Integrated Clinical Services

- The Medical Department and Facility had made progress in tracking attendance at interdisciplinary meetings. At the Integrated Clinical Services Team (ICST) meeting, participants included the required departmental representation, but attendance varied across the disciplines.
- A focus on the prevention of repeat hospitalizations and Emergency Room (ER) visits, and the necessity for active record/open chart reviews was needed. Based on observations, during the meetings, few questions regarding needed follow-up were asked. The meeting minutes did not capture critical discussion that may have occurred. ISPA reports were returned several days later, and focus should be given to a more rapid response to the Integrated Clinical Services Team request for an Interdisciplinary Team (IDT) meeting to address concerns.
- Consultant reports appeared to be reviewed and acted upon by the primary care practitioners (PCPs). Follow-up of consultation recommendations for review by the IDT, and Individual Support Plan Addendum (ISPA) development and implementation remained a challenge.

Minimum Common Elements of Clinical Care

- The Facility continued to monitor routine assessments. Each department was at a different level of compliance. Dental annual evaluations and QDRR completion was timely. Medical annual assessments and quarterly medical reviews remained noncompliant.
- There was no data for assessment of quality medical care concerning health status change. However, the documentation in the Integrated Clinical Services Team meeting provided important information from which measurable indicators have the potential to be developed for this purpose.
- The medical and psychiatric diagnoses in the active records were based on appropriate criteria. The Facility was found to remain in substantial compliance with Section H.2.

- The external and internal medical peer review audits had the potential to be used to measure timely and appropriate treatment, although these were limited in scope. However, from the data submitted, it was difficult to confirm the statistics provided. Although gathering data is essential, it is only a beginning step in the process of improving medical care. Analysis and actions based on analysis should occur in a timely manner, along with the documentation to track progress. These steps appeared lacking.
- The Medical Department and QA Department need to review their responsibilities in analysis and implementation of improvement plans. Sections H.3 to H.7 require systems development of quality improvement and monitoring to ensure the health of individuals residing at CCSSLC. The external and internal medical peer review audits are a first step in that process. The Facility will need to demonstrate that the data has resulted in improvement. It will also need to create other tools to measure quality of care to cover the many aspects of medical and health services.

<u>At-Risk Individuals</u>

- The Enhanced Risk Process training was significantly improved since several key components addressing issues such as data, supports, baselines, and specific clinical indicators that were not addressed previously were included in the most current training curriculum. In addition, on 1/25/13, the Facility began using a revised Integrated Risk Rating Form (IRRF) that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating.
- The numerous changes that had occurred with regard to the At-Risk system continued to be reflected in the documentation, specifically the varying quality of the IRRFs and the overall poor quality of the Integrated Health Care Plans (IHCPs). The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding specific actions that were taken in response to pertinent events or health issues, the lack of supporting documentation addressing actions and completion of actions continued to make the Monitoring Team's review of the Enhanced At-Risk system difficult.
- Although there were some positive observations noted from the ISP meetings the Monitoring Team observed during the onsite review, there continued to be significant problematic issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.

<u>Psychiatric Care and Services</u>

- Since the previous review, two full-time Psychiatrists had been hired, one of who was serving as Director of Psychiatric Services.
- One of the challenges continuing to confront the Psychiatry Department at CCSSLC was the integration of the necessary clinical material into the ISP documentation. Some work was underway to address this issue. The newly developed Psychiatric Medication Treatment Plan was to be completed with the Integrated Risk Rating Form at the time of the annual ISP meeting. In addition, it was expected that the increase in the number of

Psychiatrists would make it possible for a member of the Psychiatry Team to lead the discussion of this material at the individuals' annual ISP meetings.

- Another major challenge was the continued high rates of polypharmacy. The Psychiatry Department had begun to organize this data on a categorical basis. This effort should enable the Psychiatric Team to both assemble and then effectively present the necessary historical information to justify, as appropriate, the continued use of the medications.
- CCSSLC had maintained thorough documentation of the symptoms needed to establish the individual's psychiatric diagnosis, as well as the differentiation of those behaviors that derive from the psychiatric diagnosis, as opposed to those that were present on a behavioral basis. The effort to complete the annual updates to the CPEs was negatively impacted by the unexpected inability of the Psychiatrist responsible for that process to continue, but had resumed with the new locum tenens Psychiatrist.

Psychological Care and Services

- Progress was noted within Behavioral Health Services as two psychologists passed the BCBA exam and were now certified. However, several staff had decided not to pursue certification. The diversity of BSC membership, with regard to internal peer review, had become less heterogeneous over time. Progress, however, in the provision of external peer review was noted.
- Progress was evident in the completion of standardized intellectual assessments and scales of adaptive behavior in an effort to ensure that psychological assessments were updated at least every five years. However, concerns regarding the lack of clarity regarding when some of these assessments were completed and issues relative to their timely approval were noted. In addition, continued completion of Comprehensive Psychological Evaluations was noted for increasing numbers of individuals with PBSPs.
- Progress was noted in the area of PBSPs with the development of a new and improved format that was currently being piloted. Active efforts were noted with regard to writing PBSPs so that they could be understood and implemented by direct support professionals. Limited progress was noted in the timely completion of psychological assessments for newly admitted individuals, as well as in the provision of counseling supports to individuals referred for counseling.
- Continued progress in the use of a standardized PBSP monthly progress note was evidenced. This included continued improvement in the area of data display and ongoing PBSP monitoring, including continued inter-observer agreement checks on behavioral data. However, concerns were noted with the timeliness of monthly note completion.
- Lastly, some progress was noted in competency-based training. However, the provision of adequate training across the Facility for the behavioral programming of most individuals remained inadequate. As currently designed, the nature of training continued to appear resource-dependent and inefficient.

Medical Care

- The Medical Department had a new Medical Director and a new Medical Compliance Nurse. There were also two new PCPs with short-term contracts.
- The data indicated that many of the areas of preventive care (e.g., colonoscopies, mammograms, etc.) had achieved levels of substantial compliance. This will need to be monitored, as the challenge will be to sustain these accomplishments.
- There were considerable remaining areas of challenge. The Medical Director was working on a part-time basis, but the administrative duties were a full-time job. The Integrated Clinical Services Committee had important structural components in place, but more critical thinking was needed, as well as assignment of follow-ups, with accountability of closure within a short period of time. Lists of unresolved concerns awaiting an ISPA to address issues should not occur, and the turnaround response by IDTs should be rapid. The Facility might need to provide support in mentoring and guiding IDTs in developing ISPAs, which provide a quality response to the Integrated Clinical Services Committee concerns. Currently, post hospital ISPAs did not focus on preventive care, but only on the immediate stabilization of the individual.
- As noted above, death reviews were problematic. There was often not a critical review of information leading to recommendations aimed at making systemic improvement. Another major concern was the lack of follow-up to recommendations from the administrative death reviews. Some of the recommendations had system implications, but were not implemented and monitored until completion.
- Overall, considerable data was available. However, there was little evidence of analysis that led to changes in systems to improve medical services.

Nursing Care

- Since the last review, the Nursing Department had had significant staffing challenges. The fill rate had dropped to 83% in December 2012 for Registered Nurses (RNs) and 78% for Licensed Vocational Nurses (LVNs). At the time of the review, the total nursing position fill rate had improved to 97% for the RN positions, and remained at 78% for the LVN positions. This included a total of 112.7 allotted positions, including 61.2 for Registered Nurses and 51.5 for Licensed Vocational Nurses. The CNE reported that due to the staffing issues, some of the monitoring activities had not been consistently conducted, and the staffing issues were a significant factor in the lack of overall progress regarding the requirements of the Settlement Agreement for Section M.
- Some of the Facility's positive steps forward included:
    - The reliability of the Infection Control (IC) data continued to improve as reflected from data generated by comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics.
    - The Facility continued to generate data from the Real Time Audit for Acute Infections, and had begun to review the data by item, by individual, and by home.
    - Since Risk Management, Respiratory Therapy, and the Nurse Educators had been completing monthly spot checks, there had been a significant decrease in blanks found on the emergency cart checklists.

- The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at Ribbon Fish 4 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear that the consistent drills and spot checks regarding the emergency equipment were having very positive outcomes.
- The Facility had implemented procedures to accurately track the medications being brought to the buildings in an attempt to reconcile the number of excess medications that were being returned to the Pharmacy without explanation.

- Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, the actual implementation of nursing protocols, and the problematic issues regarding the under-reporting of medication variances and excessive unexplained medications being returned to the Pharmacy were very concerning at this juncture in the review process.

<u>Pharmacy Services and Safe Medication Practices</u>

- The Pharmacy Department had a new departmental Director. There was also a new Clinical Pharmacist in the department.
- Of importance, the Pharmacy Department had made inroads into the problem of unknown excess returns of medications. The Pharmacy Department revised the reporting system for medication variance to include many aspects of dispensing and administering medication. Along with this had been numerous approaches to assist the Nursing Department in resolving medication variances. These had included such projects as twice weekly medication cart exchanges, and reducing floor stock. The system had begun to capture data for medication excesses due to furloughs and refusals of medication. Although this area remained a challenge, much progress had been made.
- There remained challenges for new orders. Patient intervention reports in the WorX system were not always entered with sufficient information to determine closure. Some aspects of the Quarterly Drug Regimen Reports (QDRR) reports were consistently of high quality, while other aspects needed additional information. PCPs and psychiatry needed to demonstrate timely review of the QDRR. The Pharmacy Department was not completing the chemical restraint forms in a timely manner and completely. Adverse Drug Reaction training needed improved documentation for direct support professionals, as well as new medical and nursing staff.

<u>Physical and Nutritional Supports</u>

- The Facility Physical and Nutritional Management Team (PNMT) had five core members, including those the Settlement Agreement required. Although the Facility PNMT reported accessing various medical consultants, a review of PNMT documentation did not support routine participation by medical consultants.
- The PNMT Coordinator/RN presented a PNMT report on Fridays at the Integrated Clinical Services Team meeting, which included an update on individuals on the PNMT caseload and presentation of the status of

identified systemic issues. However, the Facility did not have the necessary sense of urgency in resolving systemic issues.

- A review of individuals' PNMT assessments, IHCPs, and Physical and Nutritional Management Plans (PNMPs) identified multiple missing essential components.
- The Monitoring Team, members of the PNMT, and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMP and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk.
- The Facility had made significant progress in completing foundational PNM training, which included the successful completion of 22 competency performance check-offs for new employees and current staff. Five individuals required individual-specific PNMP strategies. The Facility had initiated individual-specific training. However, a review of staff observation sheets for one individual over a period of 15 days indicated that a significant number of this individual's staff had not been trained.
- The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis.
- Individuals in the sample, who received enteral nutrition, were reviewed by the IDT. However, the annual assessment did not include essential components. Individuals who were transitioning to oral eating did not have a formal plan.

<u>Physical and Occupational Therapy</u>

- Individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Individuals' OT/PT assessments were improved, but additional work needed to be done to ensure essential components were present. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. Individuals who had experienced a change in status had not received an assessment update.
- OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of reviews of the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports.
- On a positive note, individuals' assistive equipment was repaired in a timely manner.

<u>Dental Services</u>

- The Dental Department continued to provide consistent quality data for nearly every aspect of dental services. This was helpful in determining areas of strength and weakness. It was evident the Dental Department

reviewed this information and applied it to the dental services for continuous improvement. Oral hygiene scores appeared to slowly improve. There was follow-up of refused appointments, as well as missed appointments. The breadth of services was provided.

- An ongoing concern for which little progress has been demonstrated was the desensitization program. Of concern, more recently, the Dental Department and Psychology Department had different lists of those individuals who might benefit from desensitization. This was a step that already should have been resolved.
- For those individuals who brushed their own teeth and had worsening oral hygiene ratings, a review for further interventions and assistance would be appropriate, along with closer tracking of their dental care in the residence and more frequent follow-ups in the dental clinic.
- The Dental Department needed to ensure policies and procedures covered all aspects of dental services.

<u>Communication</u>

- The Facility had seven Speech and Language Pathologists (SLPs), but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC. Four communication policies had been developed, but they were missing essential components.
- Individuals newly admitted to CCSSLC had communication assessments completed within 30 days. However, individuals' communication assessments were missing some essential components.
- Communication supports and interventions were not integrated in individuals' ISPs. Observations of individuals with alternative and augmentative communication (AAC) systems revealed they were not using the systems. Staff did not understand how to engage individuals with the systems. The most significant finding was the systems were not functional for the individuals. Individuals who received direct speech language (SL) therapy intervention did not have plans initiated in a timely manner, assessments did not provide a rationale for direct therapy, there was an absence of integration in the ISP, and progress notes did not include essential components. Individual-specific training and performance check-offs had not been developed and implemented for individuals with AAC systems with the exception of one individual.
- The Facility did not have a policy for monitoring communication supports. Individuals with AAC systems had not been monitored using the Compliance Monitoring form. In addition, the Facility had identified that the monitoring data it was collecting was not reliable.

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

- Progress was noted in many areas of Section S of the Settlement Agreement. However, concerns remained across the three provisions.
- Some progress was noted in the development of skill acquisition plans (SAPs) and evidence of substantial training to support better development and implementation of programming was evident. However, several elements critical to skill acquisition within the SAPs, including those targeting medical and dental desensitization, remained inadequate.

- Efforts to improve classroom and vocational attendance were also observed. In addition, efforts to improve on- and off-campus employment opportunities through vocational tours and job explorations were noted. Unfortunately, although estimates of engagement identified by the Monitoring Team appeared improved, the level was still not judged as adequate. Collection of data targeting these outcomes was likely to improve progress monitoring and corrective responding, when necessary, over time.
- Efforts directed at supporting improvement in annual assessments in the areas of living, working, and leisure activities were noted. However, concerns remained regarding the adequacy and/or timeliness of the assessments. The Facility's attention to supporting better data collection of skill programming was also noted, but these improvements did not appear to translate to improved monthly progress monitoring.

Most Integrated Setting

- Although progress was noted with regard to the inclusion of recommendations in individuals' assessments related to their appropriateness for transition to the community, some assessments still did not include this information. In addition, although professional members of the team were making and documenting a joint recommendation in the ISP, sufficient justification for the recommendations often was not found, and/or reconciliation between the various team members' written recommendations was not documented.
- Teams continued to not fully identify obstacles to referral. As a result, the obstacles report submitted to State Office included limited data, and insufficient analysis. In addition, action plans to address obstacles were largely non-existent, and when they did exist, they were not individualized.
- In reviewing Community Living Discharge Plans (CLDPs), at least three individuals were returning to CCSSLC to attend the work center program. Presumably, this was due to the fact that similar services were not available to them in a community setting. As a result, they were not fully transitioned to the community from CCSSLC, but no obstacles to their fully transitioning to the community were identified.
- Community Living Discharge Plans continued to inadequately define the necessary protections, support, and services to ensure the individual's health and safety, and little progress had been made in this regard. Most of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports.
- Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. The Post Move Monitor's comments generally provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, for individuals moving to the community with more extensive medical and physical and nutritional support needs, there was a need for the Post-Move Monitor to have access to more clinical expertise. In addition, further work was needed to ensure the Facility and IDTs took action to correct deficiencies noted.

Consent

- At the time of the review, the State Office policy on consent had not been issued. The Facility did not yet have an assessment or process to determine an individual's "functional capacity to render a decision regarding the individual's health or welfare." Facility staff indicated State Office had asked them to put a project to identify such a process on hold. As has been stated in previous reports, until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires.
- As noted in the last report, teams at the Facility had completed Individual Support Plan Addenda to identify individuals' priority level for obtaining a guardian, but the Monitoring Team noted a number of problems with the process. Based on this process, CCSSLC generated a prioritized list of individuals needing guardians, and had continued to update it on a quarterly basis. The most recent list the Facility provided was dated 2/1/13. It included a total of 248 names. Of these, 162 individuals were identified as adults with no guardians, but needing guardians.
- Since the last review, no guardians had been identified for individuals who needed them. As noted in past reports, CCSSLC had made efforts to identify potential guardianship resources. However, at the time of the review, no viable resources had been identified.
- Since the last review, the Facility had developed a Guardianship Committee, which was a positive step forward. The Committee had identified a list of 10 individuals that would most benefit from the appointment of a guardian. However, the process the Committee used included almost identical criteria to those the teams used, and appeared to be a subjective process using the Committee members' knowledge of individuals, as opposed to a more objective process that took into consideration individuals' specific needs and risks.

Recordkeeping and General Plan Implementation

- CCSSLC continued to maintain Active Records as well as Individual Notebooks. Since the last review, all individuals' historical files had been converted to the Master Record format State Office issued. A significant amount of historical information had been sent to an outside vendor to maintain.
- The Facility continued to use an Active Records Documentation Log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed.
- As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. The Facility had developed a system to track draft policies through to finalization. At that time, a process also recently had begun to track the training of staff on new or revised policies. Based on interview, the Facility was still working on a method to accurately track who had been trained, and which staff still required training.

- CCSSLC was conducting the required five records each month. A Program Compliance Monitor from the QA Department also involved in the process. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends remained in the beginning stages of development.

VI. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

DADS Policy #001.1, effective 4/10/12;
Facility Policy K.12: Behavioral Services: Restrictive Practices Committee, revised 1/24/13;
Facility Policy C: Use of Restraint: Do Not Restrain Procedures, dated 10/31/12;
CCSSLC Self-Assessment, updated 3/18/13;
CCSSLC Action Plans, updated 3/4/13;
CCSSLC Provision Action Information, dated 3/14/13;
Presentation Book for Section C;
CCSSLC Restraints – Facility Restraint Trend Report, from 1/1/13 to 1/31/13;
Individuals Restrained During Time Period Between 8/1/12 and 1/31/13;
Settlement Agreement Cross-Referenced with Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Standards: C – Protection From Harm – Restraints Guidelines, revised January 2011;
CCSSLC: Do Not Restrain List (one entry), undated;
Restrictive Practices Committee Meeting Minutes, dated: 8/1/12, 8/6/12, 8/8/12, 8/10/12, 8/13/12, 8/15/12, 8/17/12, 8/20/12, 8/24/12, 9/10/12, 9/17/12, 9/26/12, 10/3/12, 10/5/12, 10/8/12, 10/19/12, 10/24/12, 10/26/12, 10/29/12, 10/31/12, 11/5/12, 11/12/12, 11/19/12, 11/26/12, 11/28/12, 11/30/12, 12/5/12, 12/7/12, 12/10/12, 12/14/12, 12/17/12, 12/19/12, 12/21/12, 12/28/12, 12/31/12, 1/2/13, 1/4/13, 1/9/13, 1/11/13, 1/23/13, and 1/25/13.
DADS Employee Alpha Roster, dated 4/1/13;
DADTX Course Due/Delinquent, for Prevention and Management of Aggressive Behavior (PMAB) basic, as of 3/25/13;
DADTX Course Due/Delinquent, for Restraint Prevention and Rules for Use, as of 3/25/13;
Sample #C.1: 27 records of physical, mechanical or chemical restraint used in a crisis intervention for 14 different individuals, drawn from the list provided in response to 1301-II-7 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual's Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint documents requested included:
<table>
<tr><th>Individual #</th><th>Type of Restraints</th><th>Date</th></tr>
<tr><td>Individual #172</td><td>Chemical</td><td>1/15/13 at 12:35 p.m.</td></tr>
</table>

</td></tr>
</table>

Individual #275	Chemical	8/21/12 at 10:35 p.m.
Individual #40	Chemical	1/27/13 at 7:30 p.m.
Individual #238	Chemical	11/2/12 at 8:10 p.m.
Individual #109	Chemical	9/10/12 at 6:45 p.m.
Individual #172	Physical	10/25/12 at 5:08 p.m.
Individual #172	Physical	11/15/12 at 4:22 p.m.
Individual #275	Physical	9/22/12 at 6:15 p.m.
Individual #275	Physical	12/13/12 at 2:25 p.m.
Individual #40	Physical	9/29/12 at 8:18 p.m.
Individual #40	Physical	10/20/12 at 8:11 p.m.
Individual #40	Physical	1/28/13 at 9:20 a.m.
Individual #297	Physical	11/1/12 at 4:05 p.m.
Individual #297	Physical	12/7/12 at 3:25 p.m.
Individual #253	Physical	8/27/12 at 12:04 p.m.
Individual #253	Physical	10/29/12 at 7:50 a.m.
Individual #238	Physical	1/10/13 at 8:11 p.m.
Individual #109	Physical	9/11/12 at 9:58 a.m.
Individual #169	Physical	11/19/12 at 2:14 p.m.
Individual #55	Physical	1/14/13 at 6:18 p.m.
Individual #318	Physical	9/30/12 at 9:10 p.m.
Individual #312	Physical	11/2/12 at 8:18 p.m.
Individual #5	Physical	9/2/12 at 8:00 a.m.
Individual #20	Physical	8/7/12 at 4:21 p.m.
Individual #191	Physical	12/27/12 at 7:09 a.m.
Individual #297	Mechanical	11/1/12 at 4:32 p.m.
Individual #297	Mechanical	12/7/12 at 2:50 p.m.

- **Sample #C.2**

  The following documentation were requested for a selected sample of 24 staff:
  - Their start dates;
  - The dates they were assigned to work with individuals;
  - Their training transcripts showing date of most recent:
    - PMAB training;
    - Training on use of restraints; and
    - Training on abuse/neglect/exploitation; and
  - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

  The following documents were requested for a selected sample of 10 Volunteers:
  - Their start dates; and
  - The signed forms to show that each identified volunteer had acknowledged

his/her responsibility to report abuse/neglect;

- Individual Support Plans for Individual #38, Individual #141, Individual #79, Individual #310, Individual #179, Individual #359, and Individual #252;
- **Sample #C.3** chosen from the list provided in response to document request II.7.b of 67 restraint reports involving medical/dental restraint for 32 individuals, between 8/1/12 and 1/31/13. The sample of 15% of the 67 restraint episodes or 10 records was drawn, involving seven individuals. Records for this sample included: the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any applicable desensitization plan. For the following:

Individual #	Date
Individual #141	1/30/13 at 8 a.m.
Individual #141	10/12/12 at 4:50 a.m.
Individual #268	12/18/12 at 9:30 a.m.
Individual #268	11/8/12 at 8 a.m.
Individual #4	10/25/12 at 7 a.m.
Individual #4	9/24/12 at 7 a.m.
Individual #260	1/30/13 at 8:15 a.m.
Individual #74	9/26/12 at 5:30 a.m.
Individual #205	1/28/13 at 8 a.m.
Individual #136	9/4/12 at 7:30 a.m.

- **Sample #C.4** chosen from II.7a in response to the document request. The total number of chemical restraints for crisis intervention was 27, involving seven individuals. Sample size was five, involving five individuals, or 19% of the restraints and 71% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual #	Date
Individual #172	1/15/13 at 12:36 p.m.
Individual #275	8/21/12 at 10:35 p.m.
Individual #40	1/27/13 at 7:30 p.m.
Individual #238	11/2/12 at 8:10 p.m.
Individual #109	9/10/12 at 6:45 p.m.

- **Sample #C.5:** There were two restraints off-campus. Both involved the same individual on the same day, a few minutes apart. No sample was drawn.

	o **Sample #C.6:** The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period: ▪ Individual #40 o 12/25/12 at 7:45 p.m. (chemical) o 12/25/12 at 8:00 p.m. (physical) o 12/25/12 at 8:12 p.m. (physical) o 12/25/12 at 8:20 p.m. (physical) o 12/25/12 at 8:30 p.m. (physical) ▪ Individual #109 • 9/11/12 at 9:48 a.m. (physical) • 9/11/12 at 9:51 a.m. (chemical) • 9/11/12 at 9:58 a.m. (physical) • 9/11/12 at 10:16 a.m. (physical) • 9/11/12 at 10:23 a.m. (chemical) ▪ Individual #158 • 12/2/12 at 6:30 p.m. (physical) • 12/2/12 at 6:40 p.m. (physical) • 12/2/12 at 6:58 p.m. (physical) • 12/18/12 at 7:29 p.m. (physical) ▪ Individual #172 • 1/15/13 at 12:02 p.m. (physical) • 1/16/13 at 11:15 a.m. (physical) • 1/16/13 at 11:45 a.m. (physical) • 1/16/12 at 11:45 a.m. (chemical) • 1/22/13 at 1:03 p.m. (physical) o Desensitization Committee meeting minutes from 1/12/13, 1/19/13, 1/25/13, 1/28/13, and 2/15/13; o CCSSLC: Individuals with Desensitization Plans, undated; o Dental Desensitization Plans – All Information, 8/1/12 to present; o Listing of Medical Desensitization Plans, undated; o CCSSLC: Positive Behavior Support Plans, undated; o Positive Behavior Support Plans for: Individual #141, Individual #312, Individual #77, Individual #42, Individual #359, Individual #237, Individual #159, Individual #279, Individual #167, Individual #295, Individual #177, Individual #147, Individual #172, and Individual #255; o Dental Desensitization Plans, as provided, for the following: Individual #65, Individual #87, Individual #215, and, Individual #222; o Medical Desensitization Plans, as provided, for the following: Individual #215, Individual #4, Individual #128, and, Individual #156; o **Sample #C.7** was chosen from the list of individuals restrained as crisis intervention between 8/1/12 and 1/31/13. This included review of Crisis Intervention Restraint

	Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, the Crisis Intervention Plan (CIP) and Positive Behavior Support Plan (PBSP) that were in place at the time of the restraints, Individual Support Plans (ISP), ISP Addendums, ISP Action Plan, Monthly Behavioral Services Reviews, as provided, for the following individuals with restraints on the dates and times specified: ▪ Individual #40 on 12/25/12 at 7:45 p.m., 8:00 p.m., 8:12 p.m., 8:20 p.m., and 8:30p.m.; ▪ Individual #109 on 9/11/12 at 9:48 a.m., 9:51 a.m., 9:58 a.m., 10:16 a.m., and 10:23 a.m.; ▪ Individual #158 on 12/2/12 at 6:30 p.m., 6:40 p.m., and 6:58 p.m., and 12/18/12 at 7:29 p.m.; o **Sample #C.8:** Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals: • Individual #172 on 10/6/12 at 2:23 p.m., 10/25/12 at 5:08 p.m., and 1/22/13 at 1:03 p.m.; • Individual #275 on 12/23/12 at 12:50 p.m., 12/29/12 at 4:46 p.m., and 1/18/13 at 6:31 p.m.; • Individual #40 on 1/7/13 at 9:00 p.m., and 1/28/13 at 9:20 a.m.; • Individual #297 on 1/2/13 at 8:03 a.m., and 1/16/13 at 8:55 a.m.; • Individual #253 on 1/5/13 at 6:39 p.m., and 1/13/13 at 7:12 p.m.; • Individual #238 on 1/24/13 at 4:21 p.m., and 1/30/13 at 2:58 p.m.; • Individual #109 on 9/11/12 at 9:48 a.m.; • Individual #191 on 12/27/12 at 7:09 a.m., and 12/28/12 at 2:00 a.m.; • Individual #169 on 11/12/12 at 8:49 p.m., and 12/30/12 at 3:00 p.m.; • Individual #55 on 1/14/13 at 6:18 p.m.; • Individual #312 on 1/10/13 at 6:18 p.m.; • Individual #243on 1/15/13 at 5:51 p.m.; and • Individual #46 on 11/20/12 at 4:58 p.m. • **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Judy Sutton, M.A., BCBA, Director of Behavioral Health Services, and Dr. George Zukotynski, State Office Coordinator for Behavioral Health Services; o Dr. Robert Cramer, Clinical Psychologist; o Cynthia Velasquez, Director for Quality Assurance (QA); o Beverly Okin-Larkin, System Analyst; o Karen Ryder, Program Compliance Monitor for Section C; o Lindsay Hertz, Psychiatric RN; o Michelle Arteaga, Psychiatric RN; o Colleen M. Gonzales, BSHS, Chief Nurse Executive (CNE); o Ten staff members from various residential locations; and

	○ Ten individuals in various residential and day locations. • **Observations of**: ○ QA/QI Council Meeting, on 4/4/13; ○ Restrictive Practices Committee, on 4/3/13; ○ Interdisciplinary Team Meeting for Individual #324, on 4/4/13; ○ Atlantic Unit Team Meeting, on 4/2/13; ○ Incident Management Team (IMT) meeting, on 4/2/13; and Residences #511, #514, #515, #517, #522A, #522C, #524B, and #524D, and the Comfort Zone day program.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section C of the Settlement Agreement, the Facility found that it was in substantial compliance with none of the eight provisions in Section C. However the Facility did find compliance with sub-parts a and g of Section 7. This was not consistent with the Monitoring Team's findings, because the Monitoring Team found the Facility to be in compliance with Section C.3. ▪ The Facility's Self-Assessment for Section C included details drawn from the application of the Quality Assurance Monitoring Tool and referenced specific items on the tool to address the elements within each provision of the Settlement Agreement. The sample size had been increased to 65 or 20% of the instances of restraint over a nine-month period. ▪ The Quality Assurance Monitoring Tool, revised in January 2011, remained in use and the Program Monitor had changed, adding fresh perspective to the use of the tool. ▪ Data were presented for each provision by month based on random samples. ▪ The Self-ratings were comparable in most respects to those of the Monitoring Team. ▪ The Facility included Action Steps for each provision of the Settlement Agreement in its Action Plan with notations to indicate steps that had been completed. The following concerns were noted: ▪ The data provided in the Self-Assessment appeared to be from the Quality Monitoring Tools, but a notation was needed to confirm that. If any data was from a different source, that should have been noted. ▪ Monthly and Quarterly Trend Reports were being produced and reviewed by the Restrictive Practices Committee, but it was not clear how those reports were driving decisions on selection of priorities for corrective action plans. ▪ No key indicators of performance, neither process nor individual outcome, were included in the self-assessment. There is further discussion of key indicators in Section E, Quality Assurance, of this report. ▪ While Action Plans included a variety of important steps to achieving substantial compliance, it might be useful to highlight the ones that need special focus, such as the inclusion of descriptions of circumstances prior to the start of behaviors that resulted in restraint.
	Summary of Monitor's Assessment: The Monitoring Team noted significant progress in the management of the use of restraints, including:

	▪ New forms for restraint reporting had been implemented and automated; ▪ The Debriefing Reviews by Behavioral Services were documenting information with the potential to expand the understanding of the circumstances that precede behaviors that lead to restraint; ▪ The Restrictive Practices Committee appeared to have settled into a productive meeting process that was based on data and served to focus attention on reducing the use of restraints and other restrictive practices. Under new Facility policy, the committee was meeting three times each week and reviewed both restraint use, trends in use, and levels of supervision; ▪ Electronic forms were in use and had improved the quality of the forms such as the legibility of the entries; and ▪ The Facility's Avatar data system was again producing restraint data and trend reports on use of restraints. Data reports had been developed which allowed data on restraints to be arranged in a variety of ways to facilitate analysis. Some areas were identified that need attention, including: ▪ Adjustments were needed to restraint documentation forms processing to assure that dates of reviews are documented on the forms; ▪ The Restrictive Practices Committee should continue to work to achieve good attendance at meetings and to document discussions and decisions in the meeting notes; ▪ While much progress was noted, more work was needed to assure that the psychologists who complete the Debriefing forms gather information on circumstances prior to the development of restraint-necessitating behaviors, and include it in their reviews, when such information is not present on the Restraint Checklist or the Face-to-Face sheet; and ▪ While additional restraint monitors were trained, there should be clarity in the training and in practice that the restraint monitor should not be the person applying the restraint.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the</td><td>The following restraint data is provided for information purposes only, and not comparative purposes. For future reports, the Facility will be asked to provide data for the two six-month periods preceding the review. However, for this report, data requested from and produced by the Facility showed:

<table>
<tr><th>Type of Restraint</th><th>9/1/11-8/31/12 (12 months)</th><th>9/1/12-1/31/13 (5 months)</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>220</td><td>182*</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>53</td><td>27</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>10</td><td>12</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>283</td><td>221</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>
<table>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>115</td><td>67</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>82</td><td>15</td></tr>
<tr><td>Medical/dental restraints</td><td>420</td><td>111</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>373 (although this was the number the Facility provided, based on a census of approximately 250 individuals, it did not seem correct, or it was a duplicated count, which should have been made clear, if that was the case)</td><td>100</td></tr>
</table>
* Note that in August 2012 new procedures for recording restraints were adopted requiring a new restraint form to be completed and entered whenever a restraint was stopped, even if it was reinstituted a few minutes later for the same reason. This change served to increase the number of incidents of physical restraint.

<u>Prone Restraint</u>
a. Based on Facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (trend reports and lists of restraints), prone restraint was not identified as having been used.

A sample, referred to as Sample #C.1, was selected. A list is provided in the Documents Reviewed Section above.

c. Based on a review of the 27 restraint records for individuals in Sample #C.1, none (0%) showed use of prone restraint.

d. Based on interviews with 10 direct support professionals, nine (90%) were aware of the prohibition on prone restraint.

<u>Other Restraint Requirements</u>
</td><td></td></tr>
</table>

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		e. Based on document review, the Facility and State policies state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ f. In 25 of the 27 restraint records (93%), there was documentation showing that the individual posed an immediate and serious threat to self or others. The records that did not include such documentation included: Individual #275 on 8/21/12 at 10:35 p.m., and Individual #238 on 11/2/12 at 8:10 p.m. ▪ g. For the 27 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 25 (93%) contained documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. While the descriptions of the circumstances of the restraint were not always described in enough detail to permit a thorough review (as discussed with regard to Section C.8.c below) of the use of the restraint, in most cases, there was nothing to indicate staff were being punitive or that use of restraint was for convenience. Those that did not included: o Individual #275 on 8/21/12 at 10:35 p.m. (no description of the behavior); and o Individual #238 on 11/2/12 at 8:10 p.m. (no description of the behavior). ▪ h. In 25 of the records (93%), 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 as determined by the inclusion of a list of measures on the Restraint Checklist. However, none of the records provided any indication of the order in which measures were employed or the length of time it took for the measures to be employed. The records that did not include a list of measures were: o Individual #275 on 8/21/12 at 10:35 p.m.; and o Individual #238 on 11/2/12 at 8:10 p.m. ▪ i. Facility policy C.2 did identify a list of approved mechanical restraints. However, the list did not include abdominal binders, which were in use as protective mechanical restraints for self-injurious behavior. This was discussed on interview with the Behavioral Services Director who acknowledged the binders were missing from the Facility policies and that this would be corrected. Physical restraint was permitted as indicated in the PMAB training and chemical	

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		restraint was permitted if ordered by a physician. ▪ j. Based on the review of 30 restraints (Samples #C.1 and C.7), five were chemical restraints, 20 (93%) were physical restraints per PMAB, and two were mechanical restraints (seat belts) that appeared on the list in the Facility policy, and three were mechanical restraints (abdominal binders) not listed as approved in the Facility policy. According to documentation provided (i.e., "Individuals Restrained During Time Period Between 8/1/12 and 1/31/13," dated 3/8/13), at least 12 individuals were placed in restraint more than three times in any rolling thirty-day period (this does not include three individuals listed as having protective mechanical restraint). Of these twelve, a sample of three individuals (reflecting a sample of 25%) was selected for review to determine if the requirements of the Settlement Agreement were met. This sample (Sample #C.7) included Individual #40, Individual #109, and Individual #158, and specific restraints were selected. Information regarding these restraints (i.e., date and time) is listed previously in the "Review of Following Documentation" section. Documentation requested for review included Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Form, the Positive Behavior Support Plan and Crisis Intervention Plan that were in place at the time of the restraints, PBSP Progress Note for the three months surrounding the identified restraint times, the ISP and any ISPAs related to the identified restraint. Based on documentation provided, of the three individuals reviewed, two (67%) had a PBSP implemented at the time of the selected restraints (i.e., this included Individual #109 and Individual #158). The exception was Individual #40 whose admission PBSP (implemented upon arrival on 4/12/12) had expired on 7/31/12. In addition, of the three individuals reviewed, one (33%) had a CIP implemented at the time of the selected restraints. The exceptions were Individual #109 and Individual #159. The ISPA, dated 9/21/12, for Individual #109 indicated that the IDT decided not to implement a CIP. The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT recommended the development of a new CIP, but if a CIP was developed, it was not provided as requested. k. Based on the above documentation for the three individuals sampled, zero (0%) of the records indicated that restraint was not used in the absence of or as an alternative to treatment. More specifically, inadequate evidence was found that the interventions attempted prior to restraint were consistent with interventions prescribed within the PBSP, or that factors underlying observed challenging behaviors were adequately addressed by the PBSP. Examples in which inadequate treatment was present included: ▪ The restraint records for Individual #40 indicated that staff attempted interventions as outlined in his PBSP (i.e., "followed steps in the PBSP,"	

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		"prompted replacement behavior"). However, according to the ISPA, dated 1/2/13, the admission PBSP had expired and the replacement PBSP was not implemented until 1/23/13. In addition, the IDT acknowledged during the ISPA meeting "… because there is no current PBSP for direct support staff to follow this could have been a contributing factor where it concerns his restraints." Consequently, it was unclear what steps or replacement behaviors staff were referring to on the restraint checklists. ▪ Information regarding attempts to avoid restraints on the restraint records for Individual #109 was either non-existent (i.e., no information related to specific interventions as prescribed by PBSP or not even a reference to the PBSP was noted), or, if the PBSP was referenced, provided information was relatively vague (e.g., "Followed steps in the PBSP"). This phrase appears to be a formatted response that a staff member selects from available options when completing the restraint checklist. Consequently, for some of the restraint checklists, evidence was provided to indicate that staff tried to implement one or more "steps" in the PBSP. However, although information provided on the face-to-face assessments and debriefing forms was a bit more descriptive, the content revealed the same sentence (i.e., "… staff attempted to counsel with him but ineffective") across all the reviewed forms. Review of the PBSP in place at the time of the restraints, dated 8/28/12, did not include "counseling" strategies to be implemented for Individual #109 when aggressive responding was observed. Indeed, the PBSP indicated that the function of physical aggression was to gain staff or peer attention. Consequently, it appeared to the Monitoring Team that providing counseling while the individual continued to demonstrate aggression was potentially counter-therapeutic. ▪ Although the restraint records for Individual #158 appeared consistent with prescribed interventions in the PBSP, dated 12/7/12, the PBSP did not contain specific and detailed procedures in how to respond to challenging behaviors related to the condition (i.e., underlying psychiatric diagnosis) that the IDT determined was the primary factor contributing to the use of restraint. The ISPA, dated 2/22/12, documented IDT discussion of this inadequacy as well as the team's recommendation for updated comprehensive psychological assessment, CIP, and PBSP. The Settlement Agreement requires that restraints not be used in the absence of or as an alternative treatment. As noted above, staff did not adequately implement strategies prescribed with PBSP, or, in some cases, the PBSP did not contain adequate strategies to potentially prevent the need for restraint. Consequently, the Facility remained out of compliance with this section of the provision. l. Of the three individuals, considered to have been restrained with Protective Mechanical	

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		Restraint for Self-Injurious Behavior by the Facility, three restraints for one individual were reviewed (Sample C.7). Of these, three (67%) followed state policy regarding the use, management, and review of PMR. ▪ On 9/13/12 for Individual #273: There did not appear to be a fading plan in place. The Facility was in noncompliance with this provision, based on the absence of a complete list of approved mechanical restraints, restraint being used in the absence of or as an alternative to treatment, and the absence of a fading plan for the use of protective mechanical restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 14 individuals in Sample #C.1 were reviewed. Of these, five of the individuals had Crisis Intervention Plans that defined the use of restraint. a. For five individuals who had 11 restraints and had Crisis Intervention Plans, nine (82%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. The two cases where this was not so, included: ▪ Individual #275 on 9/22/12 at 6:15 p.m., where the condition of release was not clearly documented; and ▪ Individual #253 on 8/27/12 at 12:04 p.m., where the CIP called for release when the individual had been calm for two minutes, it was not clear that the required time had passed, as specified in the Crisis Intervention Plan, before release. b. For nine individuals with 16 restraints who did not have Crisis Intervention Plans, 15 (94%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. For the one who did not: ▪ Individual #40 on 1/28/13 at 9:20 a.m., there was no documentation of the reason for release. Based on this review the Facility is not in substantial compliance since the criteria level for performance is 90% on both a and b, and was achieved only on b.	Noncompliance
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	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. However, the Facility policies did not set forth a list of approved mechanical restraints that included abdominal binders. This is addressed and relates to the noncompliance finding for Section C.1. a. Review of the Facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint;	Substantial Compliance

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	approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided above in Documents Reviewed section. b. A review of training transcripts for 24 staff, and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ All 24 (100%) had current training or refresher training in RES0105 Restraint Prevention and Rules. ▪ All 24 (100%) had completed PMAB training or refresher training within the past 12 months. c. Based on interview, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint? (90%); ▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques. (90%); and ▪ How would you supervise an individual in restraint? (100%) d. As noted above with regard to Section C.1 of the Settlement Agreement, 93% 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. Although the Facility had not approved all restraints it was using in policy, this is addressed with regard to Section C.1. For the remaining requirements of this provision, the Facility achieved a rate of compliance for all of the metrics at 90% or above. As a result, the Facility was in substantial compliance with this provision.	
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	a. Based on a review of 27 restraint records (Sample #C.1), in 25 (93%) there was evidence that documented that restraint was used as a crisis intervention. The two that did not have evidence of a crisis were both chemical restraints that occurred after at least two attempts at use of physical restraint. However, the documentation explaining the use of chemical restraint did not reference the earlier behaviors and did not describe the behavior targeted by the use of chemical restraint. ▪ Individual #275 on 8/21/12 at 10:35 p.m.: the behaviors were described as "aggression toward staff" and "self-injurious behavior." There was no description	Noncompliance

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	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.	of the aggression or the self-injurious behavior in the Restraint Checklist, the Face to Face, or the Debriefing. ▪ Individual #238 on 11/2/12 at 8:10 p.m.: There was no description of the behavior in any of the documents provided. b. A sample of fourteen PBSPs were selected and reviewed to examine whether or not restraints were used for anything other than crisis intervention. This sample reflected approximately 11% of the total number of PBSPs currently in place (N=125). Of the fourteen PBSPs reviewed, 14 (100%) showed no evidence that restraint was being used for anything other than crisis intervention. That is, there was no evidence in these records of the use of programmatic restraint. In addition, as presented in the Monitoring Team's previous reports, the Facility policy did not allow for the use of restraint for reasons other than crisis intervention. However, as noted in the Monitoring Team's previous reports and found once again, additional specification with regard to consequence-based interventions in many of the reviewed PBSPs would reduce the likelihood of staff using restrictive interventions when not prescribed. That is, the utilization of the term "physical redirection" and "environmental redirection" as well as other related descriptions often appeared ambiguous and could likely lead to misinterpretation by staff. Several examples of ambiguous staff instructions were found within the current sample, including: Individual #141's PBSP that stated: "If she refuses to go to the area, staff are to physically redirect her to the area (with an additional staff member if needed);" Individual #359's plan that stated: "If verbal redirection does not work, staff may need to physically redirect;" and, Individual #147's plan that stated: " …tell [Individual] 'stop!' and physically redirect him to his room." Overall, more specification with regard to physical redirection in PBSPs would be helpful in ensuring the appropriate interventions are implemented as intended. c. In addition, Facility policy did not allow for the use of <u>non-medical</u> restraint for reasons other than crisis intervention except for use as protective mechanical restraint to prevent self-injurious behavior. d. In 27 of 27 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the Facility. The Facility issued a new policy on 10/31/12 that explained the use of the Do Not Restrain list and how it would be maintained and disseminated. That policy indicated that the PCP in conjunction with the IDT would decide which individuals to place on the "Do Not Restrain List." In interview with the Director of Behavioral Services and the State Office Coordinator for Behavioral Services, it was learned that the reasons for only one name appearing on the list were: 1) the expectation that in a crisis situation, whatever approved restraint technique that was	

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		needed to avert the crisis would be applied; and 2) most individuals with physical/medical limitations severe enough to warrant a restriction on the use of restraint would never need to be restrained. To determine the validity of this policy with regard to the people in the sample, their medical problem lists were requested and checked for any condition that would clearly preclude use of restraint. None were found and that formed the basis for the results in this metric. The Monitoring Team will consult further with the other Monitoring Teams regarding whether the Facility's practice with regard to the "Do Not Restrain" list is sufficient, and will comment further at a later time. e. A subsample of three records (i.e., Individual #172, Individual #275 and Individual #40) was chosen. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the facility to document restraint considerations/restrictions. f. A subsample of three records (i.e., Individual #275 on 12/13/12 at 2:25 p.m.; Individual #40 on 9/29/12 at 8:18 p.m., and Individual #253 on 8/27/12 at 12:04 p.m.). In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. <u>Desensitization and Other Strategies</u> Current verbal reports and provided documentation indicated that the new Desensitization Committee met five times in the last six months. Meeting minutes revealed team discussions focused on, for example, implementing baseline trials of desensitization plans for five identified individuals (i.e., including Individual #184, Individual #376, Individual #181, Individual #285, and Individual #273), visiting Rio Grande SSLC to review their dental desensitization project, creating a shared database between dental and psychology disciplines, and obtaining necessary programming items (e.g., TV, reinforcers, etc.) for the desensitization clinic. According to meeting minutes, baseline trials started on 1/28/13, and verbal reports indicated that trials were conducted over the course of a two-week period with six individuals (Note: based on the documentation provided the Monitoring Team could only identify five of the six individuals). However, data on the outcome of these trials was not evident in the latest meeting minutes, dated 2/15/13, and no summary data was provided to the Monitoring Team during the current review. However, two examples of previously completed Dental/Medical Baseline for Desensitization Plans as well as the actual desensitization plans for Individual #285 and Individual #198 were included in the Section C Presentation Book. However, it was unclear why the content included within the Dental/Medical Baseline for Desensitization Plans format utilized for Individual #198 did not match the individual's actual medical desensitization plan.	

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		Verbal reports and current documentation also indicated that the previous "Decision Tree for Dental Desensitization" had been revised. It now included more items in an effort to facilitate the determination of appropriate treatment, including either the use of sedation or the development of a SAP, behavioral contract, or desensitization plan. According to verbal report, dental clinical personnel would now be completing this revised rubric. Similar to previous findings, current reports indicated that this rubric continued to be helpful in developing more individualized interventions, when appropriate, and identifying a number of individuals who did not appear to be appropriate for desensitization plans. Interestingly, summary documentation (i.e., "Individuals with Desensitization Baselines," undated) did not indicate the completion of any decision tree rubrics since the Monitoring Team's last visit. However, several completed "old" (i.e., previous format) decision tree rubrics, as well as a listing entitled "Individuals Not Appropriate for Desensitization Plans" were included as evidence in the Section C Presentation Book. Consequently, it was unclear, based on the evidence provided, how many revised decision tree assessments had been completed since the Monitoring Team's last visit. The Monitoring Team's previous report noted that sampled dental and medical desensitization plans, at that time, included more meaningful objectives and appeared to be a substantial improvement over those found in previously reviewed desensitization plans. However, it was also noted at that time that plans contained intervention procedures that were relatively identical, included objectives that were inadequate or perhaps unattainable, and omitted several elements critical to effective skill acquisition (e.g., prompting hierarchy, error correction procedures, generalization and maintenance programming). Consequently, although improved, desensitization plans continued to require substantial improvement. Based on provided summary documentation, it appeared that approximately 12 medical and 18 dental desensitization plans were developed and implemented within the past six months between 10/1/12 and 3/31/13. In an effort to determine whether or not progress was made in improving the quality of these plans since the Monitoring Team's last visit, four medial and four dental desensitization plans (a sample of 20%) completed since 10/1/12, were randomly selected and reviewed. As reported with regard to Section S.1 of the Settlement Agreement, the current examination revealed inadequacies within all of the sampled desensitization plans, and, therefore, they continued to not meet the requirements of the Settlement Agreement. These inadequacies included the lack of measurable objectives, inadequate task analyses, omission of prompting hierarchy and error correction procedures, and the lack of strategies to support maintenance and generalization. It should be noted that these inadequacies were consistent with those identified in the Monitoring Team's previous reports.	

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		The Monitoring Team's previous report noted efforts in developing an actual desensitization clinic within the Angelfish building. Currently, this clinic did not appear to be included in future plans for desensitization activities in lieu of the utilization of the actual dental clinic. The Monitoring Team views opportunities for effective skill acquisition, including medical and dental desensitization programming, in the natural environment as more functional and likely more beneficial. Based on the metrics for this review, the Facility met the requirements of metrics a, b, c, d, e and f. However, the issue that remained was related to desensitization and other strategies to reduce to the extent possible the use of restraint for dental and medical purposes.	
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	a. Review of Facility training documentation showed that there was not an adequate training curriculum on the application and assessment of restraint. The curricula presented for review did not include instructions to Restraint Monitors that: ▪ The staff who apply the restraint should not act as the Restraint Monitor for the same event. The purpose of having a Restraint Monitor is to ensure that an experienced staff member is monitoring the restraint with an objective point of view. To have that objectivity, the Restraint Monitor must not be engaged in the restraint. There were numerous instances in this review where the Restraint Monitor was also the person applying the restraint. Three examples include: o Individual #297 on 12/7/12 at 3:25 p.m.; o Individual #169 on 11/19/12 at 2:14 p.m. and o Individual #312 on 11/2/12 at 8:18 p.m. ▪ The Restraint Monitor must review the Restraint Checklist to assure that there is a clear description of the circumstances of the restraint as evidenced by the missing information noted with regard to Section C.8. b. This training was competency-based in that it included a test with some examples of cases. c. Based on review of training records, 191 staff at the Facility who performed the duties of a restraint monitor successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint. Based on a review of 27 restraint records (Sample #C.1), a face-to-face assessment was conducted: d. In 22 out of 27 incidents of restraint (81%) by an adequately trained staff member. Records that did not contain documentation of this included: ▪ Individual #40 on 9/29/12 at 8:18 p.m.; ▪ Individual #40 on 1/28/13 at 9:20 a.m.;	Noncompliance

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	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.	▪ Individual #312 on 11/2/12 at 8:18 p.m.; ▪ Individual #20 on 8/7/12 at 4:21 p.m.; and ▪ Individual #5 on 9/2/12 at 8:00 a.m. e. In 25 out of 27 instances (93%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: ▪ Individual #40 on 1/27/13 at 7:30 p.m.; and ▪ Individual #5 on 9/2/12 at 8:00 a.m. f. In 22 instances (81%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included: ▪ Individual #275 on 8/21/12 at 10:35 p.m. (blanks incomplete on Face-to-Face); ▪ Individual #238 on 11/2/12 at 8:10 p.m. (no restraint monitor listed on form and no information on restraint checklist to review); ▪ Individual #109 on 9/10/12 at 6:45 p.m. (Face-to-Face recorded "not applicable" for contact with psychologist when the restraint was chemical and contact was required, and that restraint was stopped when no longer a danger, but it was a chemical restraint when a stop time cannot be determined); ▪ Individual #318 on 9/30/12 at 9:10 p.m. (Face-to-Face noted contact with psychologist prior to chemical restraint, but this was not a chemical restraint); and ▪ Individual #5 on 9/2/12 at 8:00 a.m. (No Face-to-Face sheet.). g. In 16 instances (59%), the documentation showed that an assessment was completed of the consequences of the restraint. In most cases, the face-to-face form was filled in, but did not add any explanation of inconsistencies in the reported information. Records that did not contain sufficient documentation of the consequences of restraint included: ▪ Individual #238 on 11/2/12 at 8:10 p.m. (The face-to-face form was completed, but the Restraint Checklist was not. A note of explanation was needed.) ▪ Individual #275 on 12/13/12 at 2:25 p.m. (The Face-to-Face indicated there was no injury, yet reported a staff injured); ▪ Individual #40 on 9/29/12 at 8:18 p.m. (No mention of the injury documented on the Restraint Checklist); ▪ Individual #40 on 10/20/12 at 8:11 p.m. (Same as above); ▪ Individual #297 on 12/7/12 at 3:25 p.m. (There was an injury noted on the Restraint Checklist, but the Face-to-Face indicated the injury report was not applicable without explanation); ▪ Individual #109 on 9/11/12 at 9:58 a.m. (There was an indication of safety issues with no explanation); ▪ Individual #169 on 11/19/12 at 2:14 p.m. (It was noted that a doctor or a nurse was needed with no explanation and no obvious connection to the Restraint Checklist);	

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		▪ Individual #55 on 1/14/13 at 6:18 p.m. (Same as above); ▪ Individual #312 on 11/2/12 at 8:18 p.m. (Issues with safety were identified with no explanation.); ▪ Individual #5 on 9/2/12 at 8:00 a.m. (No Face-to-Face form); ▪ Individual #297 on 11/1/12 at 4:32 p.m. (Face-to Face indicated an injury report had been started, but the Restraint Checklist indicated there was no injury.) Three individuals were reported to have alternate schedules of monitoring. One was Individual #273. He was being restrained with an abdominal binder to prevent self-injurious behavior, including removing of a G-tube. A psychologist signed the plan for the alternate schedule. No plans for alternative schedules of monitoring were offered that had been signed by physicians. Therefore, the following metrics could not be evaluated during this review, but will be during upcoming reviews: ▪ h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 23 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #172, Individual #275, Individual #40, Individual #297, Individual #253, Individual #238, Individual #109, Individual #191, Individual #169, Individual #55, Individual #312, Individual #243, and Individual #46), there was documentation that a licensed health care professional: ▪ j. Initiated monitoring at least every 30 minutes from the initiation of the restraint in 19 (83%) of the instance of restraint. Records that did not contain documentation of this included: Individual #275 on 1/18/13 at 6:31 p.m.; Individual #253 on 1/13/13 at 7:12 p.m.; Individual #191 on 12/27/12 at 7:09 a.m.; and Individual #243 on 1/15/13 at 5:51 p.m. ▪ k. Monitored and documented vital signs in 16 (70%) episodes. Records that did not contain appropriate documentation of this included: Individual #172 on 10/6/12 at 2:23 p.m., and 1/22/13 at 1:03 p.m.; Individual #275 on 12/29/12 at 4:46 p.m.; Individual #253 on 1/5/13 at 6:39 p.m.; Individual #191 on 12/28/12 at 2:00 a.m.; Individual #169 on 12/30/12 at 3:00 p.m.; and Individual #243 on 1/15/13 at 5:51 p.m. Problematic issues that resulted in noncompliance included the vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. ▪ l. Monitored and documented mental status in 14 (61%) episodes. Records that did not contain appropriate documentation of this included: Individual #172 on 10/25/12 at 5:08 p.m., and 1/22/13 at 1:03 p.m.; Individual #275 on 12/23/12 at 12:50 p.m., and 12/29/12 at 4:46 p.m.; Individual #297 on 1/2/13 at 8:03 a.m.; Individual #191 on 12/27/12 at 7:09 a.m., and 12/28/12 at 2:00 a.m.; Individual #169 on 12/30/12 at 3:00 p.m.; and Individual #243 on 1/15/13 at 5:51 p.m.	

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		Problematic issues that resulted in noncompliance included either the mental status was not recorded, or was generic such as "alert, and oriented" without a specific description of the behavior included to support the generic documentation. Providing a specific description of the individual that reflects their mental status such as "yelling at staff with fists clenched" clearly reflects the mental status of the individual rather than using generic statements. From discussions with the Chief Nurse Executive, since the last review, the Facility's Nursing Department had not yet established a formal system to review and analyze these data or address the problematic issues found. The same was true for the data related to Section C.6 addressing the documentation of assessment by a licensed health care professional to determine whether there were any restraint-related injuries or other negative health effects. A sample of off-site restraints was not reviewed, but during upcoming reviews should off-campus restraints occur, the following metrics will be assessed: A licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in __ out of ___ (__%). Records that did not contain documentation of this included… ▪ n. Monitored and documented vital signs in ___ (___%). Records that did not contain documentation of this included… ▪ o. Monitored and documented mental status in ___ (___%). Records that did not contain documentation of this included… Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 15% of the individuals for whom medical restraint was used. (A list of records for Sample C.3 is provided above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In none out of 10 (0%), the physician specified the schedule of monitoring required. However, it appeared there was a standard procedure for this type of monitoring based on the fact that physicians did not specify monitoring, yet some monitoring was done. However, the Monitoring Team could not find any reference to standard monitoring in the policies or procedures provided; ▪ q. In 0 out of 10 (0%), the physician specified the type of monitoring required. However, it appeared there was a standard procedure for this type of monitoring based on the fact that physicians did not specify monitoring, yet some monitoring was done. However, as noted above, the Monitoring Team could not find any reference to standard monitoring in the policies or procedures provided; and ▪ r. In one out of 10 of the medical restraints (10%), appropriate monitoring was	

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		completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. (Individual #141 on 1/30/13 at 8 a.m.) Based on this review, the Facility was not in substantial compliance, because the curriculum and training for restraint monitors was not adequate, staff who signed as Restraint Monitors were not always on the list of trained staff, nursing documentation was insufficient in a number of cases, assessment of application and consequences of restraint were not always well documented, and there was no documentation that physicians had ordered schedules of monitoring or types of monitoring for medical restraints.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 27 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ a. In 26 (96%), continuous one-to-one supervision was provided (Individual #55 on 1/14/13 at 6:18 p.m. specified 1:2); ▪ b. In 27 (100%), the date and time restraint was begun; ▪ c. In 27 (100%), the location of the restraint; ▪ d. In 19 (70%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. Those that did not included: o Individual #275 on 8/21/12 at 10:35 p.m.; o Individual #40 on 1/27/13 at 7:30 p.m.; o Individual #238 on 11/2/12 at 8:10 p.m.; o Individual #297 on 12/7/12 at 3:25 p.m.; o Individual #318 on 9/30/12 at 9:10 p.m.; o Individual #5 on 9/2/12 at 8:00 a.m.; o Individual #191 on 12/27/12 at 7:09 a.m.; and o Individual #297 on 12/7/12 at 2:50 p.m. ▪ e. In 21 (78%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8 ▪ f. In 25 (93%), the specific reasons for the use of the restraint. (Individual #275 on 8/21/12 at 10:35 p.m. and Individual #238 on 11/2/12 at 8:10 p.m.) ▪ g. In 27 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 27 (100%), the names of staff involved in the restraint episode; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, for the 22 physical or mechanical restraints in Sample #C.1 including: o i. In 21 (95%), the observations documented every 15 minutes and at release. The restraint for Individual #40 on 1/28/13 at 9:20 a.m. lasted 20 minutes, but no observations were recorded for the last 17 minutes or	Noncompliance

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		at release. o j. In the one restraint that lasted more than 15 minutes, in none (0%) of those restraints, the specific behaviors of the individual that required continuing restraint (Individual #40 on 1/28/13 at 9:20 a.m.); and o k. In 27 (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 ▪ l. In 27 (100%), the level of supervision provided during the restraint episode; and ▪ m. In 22 of 22 physical or mechanical restraints (100%), the date and time the individual was released from restraint. n. Based on a review of 23 restraint records for 13 individuals for restraints that occurred at the Facility (i.e., Individual #172, Individual #275, Individual #40, Individual #297, Individual #253, Individual #238, Individual #109, Individual #191, Individual #169, Individual #55, Individual #312, Individual #243, and Individual #46): ▪ In 16 (70%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. Records that did not contain documentation of this included: Individual #172 on 1/22/13 at 1:03 p.m.; Individual #275 on 12/29/12 at 4:46 p.m., and 1/18/13 at 6:31 p.m.; Individual #253 on 1/5/13 at 6:39 p.m., and 1/13/13 at 7:12 p.m.; Individual #312 on 1/10/13 at 6:18 p.m.; and Individual #243on 1/15/13 at 5:51 p.m. Problematic issues that resulted in noncompliance included either the injury section being left blank, or discrepancies found between the Restraint Checklists indicating that there were no injuries and documentation found on the Client Injury Reports and/or Integrated Progress Notes indicating that an injury had in fact occurred. o. In a sample of 27 records (Sample #C.1), restraint debriefing forms had been completed for 26 (96%). While the debriefing forms were used in many cases to add information to the record as to the events that led to the behaviors that necessitated restraint, not all of them did. This might be because the Debriefing Form did not prompt the reviewer to ask questions about what was going on before the behavior that led to the crisis occurred. In addition, not all of them used the opportunity to explain any missing or conflicting information in the restraint checklist and face-to-face forms, such as why one form indicated an injury and the companion form did not. (As noted with regard to metric C.6.n above.) The debriefing forms did not contain the name of the psychologist that could have been different from the name of the psychologist who was initially contacted and listed on the restraint checklist. Consequently, while a high percentage of the forms were completed, they were not always helpful in determining the circumstances of the	

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		restraint. (As discussed in further detail with regard to Section C.8.) p. A sample of 10 individuals subject to medical restraint was reviewed (Sample #C.3), and in none (0%) was there evidence that the monitoring had been completed as required by the physician's order, since there were no orders for type or schedule of monitoring by a physician. Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. This sample of five individuals who were the subject of a chemical restraint was reviewed. q. In three (60%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. (Those that did not have documentation were Individual #275 on 8/21/12 at 10:35 p.m. and Individual #238 on 11/2/12 at 8:10 p.m.) However, for the three records where the forms were present, neither the names of the psychologists nor the names of the health care professionals who consulted were present. It would be best to include those names on the forms, rather than relying on the indication in the restraint checklist as to which professionals were contacted initially. Based on this review, the Facility is not in substantial compliance due to metrics for which the Facility's scores fell below 90%, and due to the lack of physicians' orders for the types and schedules of monitoring for medical restraints.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to the document Individuals Restrained During Time Period Between 8/1/12 and 1/31/13, dated 3/8/13, at least 12 individuals were placed in restraint more than three times in any rolling thirty-day period (i.e., this does not include three individuals listed as having protective mechanical restraint). Of these 12, a sample of three individuals (reflecting a sample of 25%) was selected for review to determine if the requirements of the Settlement Agreement were met. Sample #C.7 included Individual #40, Individual #109, and Individual #158. The specific restraints by date and time are listed above in the "Review of Following Documentation" section.	Noncompliance

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		Based on documentation provided, of the three individuals sampled, three (100%) of the individuals' teams met to review the restraints selected for review as identified below: ▪ An ISPA, dated 1/2/13, indicated that the IDT for Individual #40 met and discussed the restraints that occurred on 12/25/12. The ISPA template designed to facilitate team review following more than three restraints in any rolling 30-day period appeared to be completed. ▪ An ISPA, dated 9/21/13, indicated that the IDT for Individual #109 met and discussed the restraints that occurred on 9/11/12. The ISPA template designed to facilitate team review of more than three restraints in any rolling 30-day period appeared to be completed. ▪ An ISPA, dated 2/22/13, indicated that the IDT for Individual #158 met and discussed the restraints that occurred on 12/2/12 and 12/18/12. The ISPA template designed to facilitate team review following more than three restraints in any rolling 30-day period appeared to be completed. It should be noted that, although the IDT for Individual #158 met and discussed the identified restraints (i.e., those occurring on 12/2/12 and 12/18/12), the meeting was held approximately two months after the restraints occurred. This did not reflect a timely and responsive review of the incidents and potentially placed the individual at continued risk. Indeed, the potential for further negative outcomes for Individual #158, due to such a delay, seemed to be accentuated by the IDT's decision to develop a new comprehensive psychological assessment, a new PBSP, and a new CPI. Based on the above findings, the subsequent review related to Sections C.7.a through C.7.g of the Settlement Agreement included the examination of only those ISPAs completed in a timely manner, including those for Individual #40 and Individual #109. Because the team did not meet within a reasonable amount of time following more than three restraints in a 30-day rolling period for Individual #158, this was considered noncompliance for each of the subsections. Of the three individuals reviewed, none (0%) of the individuals' teams adequately reviewed the individuals' adaptive skills. The following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 1/2/13, did not provide evidence that the IDT specifically reviewed and discussed issues related to current adaptive functioning, beyond communication skills, for Individual #40. ▪ The ISPA, dated 9/21/13, did not provide evidence that the IDT specifically reviewed and discussed issues related to current adaptive functioning, beyond communication skills, for Individual #109. ▪ The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT did not meet within an acceptable time period following more than three restraints in a 30-day	

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		rolling period. Of the three individuals reviewed, one (33%) of the individuals' teams adequately reviewed the individual's biological, medical and psychosocial factors. More specifically, based on the ISPA, dated 1/2/13, it appeared that the IDT for Individual #40 specifically reviewed and discussed issues related to biological/medical and psychosocial factors as well as their potential relation to the challenging behaviors that necessitated restraint. However, the following are examples of where teams failed to do this adequately: ▪ Based on the ISPA, dated 9/21/12, it was unclear why the IDT for Individual #109 did not discuss the primary issue (i.e., potential sexual responding directed toward another individual) related to the increase in supervision that precipitated the need for restraint. More specifically, it appeared that the IDT had identified issues related to sexual responding (i.e., lifting a female peer's shirt) as the precursor to an increased level of supervision and subsequent agitation, aggression, and necessary restraint. However, the team never discussed issues related to sexuality or how to prevent or ameliorate this issue in the future. ▪ The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT did not meet within an acceptable time period following more than three restraints in a 30-day rolling period.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, two (67%) of the individuals' teams adequately reviewed the potentially contributing environmental conditions. More specifically, the IDTs for Individual #40 and Individual #109 appeared to specifically review and discuss issues related to potential contributing environmental conditions. However, the following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT did not meet within an acceptable time period following more than three restraints in a 30-day rolling period.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals reviewed, one (33%) individual's team adequately reviewed or performed structural assessments of the behavior provoking restraints. More specifically, the IDT for Individual #40 appeared to adequately examine the precursors of each restraint and discussed the need to complete a new comprehensive psychological assessment. However, the following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 9/21/12, for Individual #109 identified the increased level of supervision as a potential precursor to the challenging behavior that led to the restraint. However, other than identifying increased supervision as the factor that provoked the observed aggression and self-injury, the IDT failed to consider the role of other antecedents or setting events (e.g., access and/or denied access	Noncompliance

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		to preferred peers, including the potential of issues related to sexuality) that may have contributed to the challenging behavior. In addition, this information did not appear to be reviewed against the current FBA. Lastly, although all of the incidents involved self-injury, the IDT did not appear to review and/or consider the inclusion of this challenging behavior within current psychological assessment. ▪ The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT did not meet within an acceptable time period following more than three restraints in a 30-day rolling period.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Of the three individuals reviewed, one (33%) individual's team adequately reviewed or performed functional assessments of the behavior provoking restraints. More specifically, the IDT for Individual #40 appeared to adequately examine the variables that were potentially maintaining the behavior provoking restraints as well as identified the need for a current comprehensive psychological assessment, including a functional behavior assessment. Current documentation evidenced that a comprehensive psychological assessment was in the process of being completed (draft dated 3/29/13). However, the following are examples of where teams failed to do this adequately: ▪ The ISPA, dated 9/21/12, for Individual #109 identified the increased level of supervision as a potential precursor to the challenging behavior that led to the restraint. However, other than identifying increased supervision as the factor that provoked the observed aggression and self-injury, the IDT failed to consider how this intervention was potentially counter-therapeutic based on the finding of the comprehensive psychological assessment, dated 5/18/12, that identified attention as the maintaining function of aggressive behavior. ▪ The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT did not meet within an acceptable time period following more than three restraints in a 30-day rolling period.	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	Of the three individuals reviewed, two (67%) had a PBSP implemented at the time of the selected restraints. The exception was Individual #40 whose admission PBSP (implemented upon arrival on 4/12/12) had expired on 7/31/12. Of the two individuals in the sample with PBSPs in place at the time of the restraints (i.e., Individual #109 and Individual #158), the following was found based on review of these PBSPs: ▪ One (50%) specified the objectively defined behavior to be treated that led to restraints. o The exception was the PBSP, dated 8/28/12, for Individual #109. It did not identify or define self-injury. Review of identified restraints evidenced aggression and self-injury as rationale in all sampled episodes. ▪ One (50%) specified functional replacement behaviors (i.e., alternative, positive adaptive behaviors) to replace the behavior that initiated the use of restraint.	Noncompliance

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	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;	○ The exception was the PBSP, dated 8/28/12, for Individual #109. It did not identify any replacement or adaptive behavior for the underlying attention function. ▪ One (50%) specified, as appropriate, the use of other programs (preventative and/or consequence-based strategies) to reduce or eliminate the use of restraint. ○ The exception was the PBSP, dated 8/28/12, for Individual #109. It did not identify adequate preventative or consequence based interventions targeting the underlying attention function of aggressive behavior. Of the three individuals reviewed, one (33%) had a CIP implemented at the time of the selected restraints. The exceptions were Individual #109 and Individual #159. The ISPA, dated 9/21/12, for Individual #109 indicated that the IDT decided not to implement a CIP. The ISPA, dated 2/22/13, for Individual #158 indicated that the IDT recommended the development of a new CIP, but if a CIP was developed, it was not provided as requested. Of the single individual in the sample with a CIP in place at the time of the restraints (i.e., Individual #40), the following was found based on review of these CIPs: ○ In one (100%), the type of restraint authorized was delineated; ○ In one (100%), the maximum duration of restraint authorized was specified; ○ In one (100%), the designated approved restraint situation was specified; and ○ In one (100%), the criterion for terminating the use of the restraint was specified.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	There was no evidence found within the sampled documentation to indicate that treatment integrity was examined for any of the PBSPs of the three individuals selected. As a result, it was not possible to confirm a high degree of treatment integrity as related to the implementation of PBSPs and CIPs, as applicable, for Individual #40, Individual #109, or Individual #158.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Of the three individuals reviewed, two (67%) had a PBSP implemented at the time of the selected restraints. The exception was Individual #40 whose admission PBSP (implemented upon arrival on 4/12/12) had expired on 7/31/12. Of the two individuals with PBSPs in place at the time of the identified restraints, one (50%) of the individuals' teams adequately reviewed and/or made recommendations to revise the PBSP. More specifically, the IDT for Individual #158 appeared to critically review the current PBSP and made recommendations for necessary revisions. However, the following is an example of where a team failed to do this adequately: ○ The ISPA, dated 9/21/12, for Individual #109, did not reflect IDT discussion	Noncompliance

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		focused on the consistent observation of self-injury (concurrent with aggression) across all crisis episodes that necessitated restraint. The lack of identification in the PBSP of SIB as a target behavior should have prompted some discussion as well as potential revision of the PBSP. In addition, as identified with regard to Section C.7.e, the IDT should have identified the need for a replacement behavior as well as antecedent- and consequence-based interventions target aggression as maintained by social attention.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The Facility process for review of a restraint required the restraint checklist to be reviewed by the Restraint Monitor and documented on the Face-to-Face form. The psychologist reviewed both forms in conjunction with completing the debriefing sheet. The restraint record was to be reviewed by the Unit Team within three days of the restraint, and the date of the review was to be noted on the Restraint Checklist. The Unit Team might not have the debriefing sheet at the time of their review, which could happen on the next day. The IMRT was to review the record within three business days, and the date was to be noted on the Restraint Checklist. The IDT was to review the restraint if it was one of three restraints in a rolling 30-day period or if it received a referral from the Unit Team or IMRT. In addition, the Restrictive Practices Committee reviewed individual restraints and monitored data for trends. A sample of documentation related to 27 incidents of crisis intervention restraint was reviewed (Sample #C.1), including the Unit Team meeting and IMRT meeting minutes, Restraint Reduction Committee minutes, and ISP addenda, where available. This documentation showed that: ▪ a. In 11 (41%), the review by the Unit IDT occurred within three business days of the restraint episode, and this review was documented on the Restraint Checklist. However, the electronic forms did not include signatures, though they did list the name of the person making the entry. However, although a date was included, the review by the Unit IDT could not be verified, since the minutes of the related team meetings were not provided. ▪ b. In nine (33%), the review by the IMRT occurred within three business days of the restraint episode, and this review was documented on the Restraint Checklist. However, the electronic forms did not include signatures, though they did list the name of the person making the entry. However, although a date was included, the review by the IMRT could not be verified, since the minutes of the related team meetings were not provided ▪ c. In 15 (56%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment/Debriefing form. While metrics C.5.f and g enumerate records in which the review of the	Noncompliance

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		application or consequences of restraint were incomplete, this provision considers whether the circumstances, including the events that were occurring just prior to the behavior that resulted in restraint were fully explained either in the Restraint Checklist, the Face-to-Face or the Debriefing forms. When they are not fully described, it is difficult to see how the Unit Team or the IMRT could determine whether to request additional review and action by the individual's IDT. Records that did not have a determination of the circumstances of the restraint included: o Individual #172 on 1/15/13 at 12:35 p.m.; o Individual #275 on 8/21/12 at 10:35 p.m.; o Individual #40 on 1/27/13 at 7:30 p.m.; o Individual #238 on 11/2/12 at 8:10 p.m.; o Individual #40 on 1/28/13 at 9:20 a.m.; o Individual #297 on 12/7/12 at 3:25 p.m.; o Individual #109 on 9/11/12 at 9:58 a.m.; o Individual #55 on 1/14/13 at 6:18 p.m.; o Individual #318 on 9/30/12 at 9:10 p.m.; o Individual #5 on 9/2/12 at 8:00 a.m.; o Individual #191 on 12/27/12 at 7:09 a.m.; and o Individual #297 on 12/7/12 at 2:50 p.m. Since the forms were electronic, the name, but not the signature of the staff responsible for documenting the Face-to-Face review was included. The name of the reviewing psychologist was not included on the Debriefing form. The Debriefing form should be modified to include the name and date of the Debriefing, since it may differ from that of the Face-to-Face. ▪ d. It could not be determined if the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. The determination could not be made since reviews by the Unit Team and the IMRT were not routinely included with the documents, even though they were requested. ▪ e. It could not be determined if referrals were made to the interdisciplinary team, as appropriate since reviews were not submitted. However, the Monitoring Team noted that the IDTs did review many of the restraints in the sample either immediately after the restraint, or within a month as part of a review of the individual's ISP or in conjunction with the review required when three restraints occurred within a rolling 30 day period, as evidenced by the inclusion of ISP	

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		addenda. The quality of these latter reviews is discussed with regard to Section C.7, but overall did not meet the requirements of the Settlement Agreement. ▪ f. It could not be determined if appropriate changes were made to the individuals' ISPs and/or PBSPs, based on referrals, since there was no documentation of referrals. Based on this review, the Facility is not in substantial compliance with this provision. The Facility did not achieve a score of 90% for the metrics included in this section.	

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, using techniques outlined in the PBSPs to prevent and address behaviors, and documenting their use adequately, when appropriate, on restraint checklists. (Section C.1)
2. The quality of the documentation of the events preceding the restraint should continue to 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, including the order of the alternatives to restraint and the time involved in those efforts. (Sections C.1, C.5, and C.8)
3. Staff should be trained to follow the PBSPs prior to the use of restraints, and to document the steps taken on the Restraint Checklist. When Restraint Monitors note lack of documentation, they should ask staff for clarification and record the information on the debriefing form. (Sections C.1 and C.3)
4. If the Facility is going to continue to use abdominal restraints as protective mechanical restraint to prevent self-injurious behavior, then the abdominal binder should be added to the list of permitted mechanical restraints. (Section C.1)
5. When PMAB procedures are referenced in consequence-based intervention sections in PBSPs, a reference should be provided as to whether or not a Crisis Intervention Plan is currently in place and to direct staff to related strategies prescribed within the CIP. (Section C.4)
6. In PBSPs, the term "environmental redirection" should be clarified to include the specific type of prompt prescribed (i.e., verbal, gestural, and/or physical). (Section C.4)
7. In PBSPs, the term "physical redirection" should be more specific regarding the acceptable amount of physical force (i.e., that it does not include force over active resistance). (Section C.4)
8. The Facility should ensure that desensitization plans contain necessary elements for effective skill acquisition. (Section C.4)
9. The curriculum for training Restraint Monitors should be enhanced to ensure understanding of antecedent behaviors, documentation of alternatives that are tried prior to restraint, and the need to include indications of the time spent attempting to prevent the restraint. (Section C.5)
10. The Facility should ensure that restraints, such as medical restraints, have documentation to support alternative schedules of monitoring. (Section C.5)
11. The Facility should ensure that a licensed health care professional timely and regularly monitors, and appropriately documents the vital signs, and the mental status of an individual in restraints at least every 30 minutes from the start of the restraint episode, and for two hours except for a medical restraint pursuant to a physician's order. (Section C.5)
12. The Facility should develop and implement a system to ensure that auditing data regarding restraints is being regularly reviewed by nursing, and that plans of correction are implemented addressing the problematic issues identified. (Section C.5)

13. The Facility should ensure that nursing staff assesses and appropriately documents any restraint-related injury. (Section C.6)
14. The quality of the Restraint Debriefing and Face-to-Face forms should be improved by ensuring staff complete forms accurately, and fill in all information, particularly explanatory comments and dates of review by the Unit Teams and the Incident Management Team. (Sections C.6 and C.8)
15. The Facility should ensure that ISPAs for more than three restraints in a 30-day rolling period are completed within an acceptable time period (Section C.7)
16. The Facility should consider revising the ISPA format for more than three restraints in any 30-day period to highlight the IDTs' review of data (i.e., target and replacement data, IOA, and treatment integrity data), as well as create a separate section for the review of adaptive skills. (Section C.7)
17. The Facility should provide re-training for QDDPs and other IDT members that facilitate and document meetings when discussing the use of more than three restraints in a 30-day period, including focused attention on reviewing an individual's adaptive skills. (Section C.7)
18. The Restrictive Practices Review Committee should follow its process for reviewing forms consistently and vigorously to identify errors and inconsistencies. (Section C.8)
19. The Unit Incident Management Review Teams should keep minutes or insert sufficient information into its log to document its review of restraints and any recommendations that are made, and track any changes that are needed so that it is clear when issues related to a restraint have been addressed. (Section C.8)
20. The analysis of data for trends by the Restrictive Practices Review Committee should drive decisions on priorities for corrective action plans to address identified issues. (Facility Self-Assessment)
21. Key indicators of performance in use of restraints should be selected and monitored. (Facility Self-Assessment)

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 Self-Assessment, updated 3/18/13; o CCSSLC Action Plans, updated 3/18/13; o CCSSLC Provision Action Information, dated 3/14/13; o Presentation Book for Section D; o Abuse/Neglect/Exploitation (A/N/E) Investigations between 8/1/12 and 1/29/13, undated; o CCSSLC Abuse Neglect and Exploitation – Monthly Trending Report, from 12/1/12 to 12/31/12 and from 1/1/13 to 1/31/13; o Investigations Conducted Solely by Facility between 7/9/12 and 1/31/13; o CCSSLC Unusual Incidents – Monthly Trending Report, from 12/1/12 to 12/31/12 and 1/1/13 to 1/31/13; o CCSSLC Staff Status Tracking – by Date, dated 2/20/13; o List of Eight CCSSLC individuals who are currently on chronic caller list, undated; o Course Delinquency List for ABU0100, Abuse and Neglect, dated 2/28/13; o Course Delinquency List for UNU0100, Unusual Incidents, dated 2/28/13; o Adult Protective Services (APS) Training Transcript Crosswalk – Corpus Christi, undated; o Individual Support Plan (ISP) Meeting (Facilitation and Documentation), dated 4/4/13; o CCSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 10/11/12; o List of CCSSLC Volunteers with corresponding date on which background check was completed, dated 2/6/13; o Atlantic Unit Management Review Team Meeting Minutes for 4/2/13; o Memo from Jon Breseman re: Monitor versus Temporary Work Reassignment (TWR), dated 3/12/12; o CCSSLC Coaching Guide, revised 11/15/12; o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) reports of 10/19/12 and 12/20/12; o **Sample #D.1** included a sample of 30 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports, drawn from the list submitted by the Facility in response to document request III.20, including: Investigation reports #42447394, #42458895, #42468204, #42482318, #42507247, #42517894, #42518261, #42529626, #42536961, #42540060, #42541436, #42545453, #42548373, #42549539, #42550611, #42552898, #42555220, #42558828, #42559755, #42567752, #42585861, #42589482, #42598532, #42611020, #42614643, #42615580, #42630015, #42636819, #42637551, and #42665181; o **Sample #D.2** included a sample of five investigation reports that were drawn from the list

	of Investigations Completed Solely By the Facility between7/9/12 and 1/31/13, including: Facility #12-440, #13-036, #13-069, #13-034, and #13-071; o **Sample # D.3**: No additional reports were selected for review; o **Sample#D.4**: ISPs reviewed, including: Individual #38, Individual #79, Individual #141, Individual #179, Individual #252, Individual #310, and Individual #359; and o **Sample #D.5**: Four of the DFPS investigations from Sample #D.1 where abuse or neglect was confirmed and two of the Facility investigations from Sample #D.2, including the following investigations: Facility investigations #13-036 and #13-071 and DFPS Investigations #42549539, #42550611, #42552898 and #42630015. ▪ **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Cynthia Velasquez, Director for Quality Assurance; o Jon Breseman, Incident Management Coordinator (IMC); o John Cortez, Investigator; o Elena Martinez, Program Monitor; o Ten staff members from various residential locations; and o Ten individuals in various residential and day locations. ▪ **Observations of**: o QA/QI Council Meeting, on 4/4/13; o Restrictive Practices Committee, on 4/3/13; o Interdisciplinary Team Meeting for Individual #324, on 4/4/13; o Atlantic Unit Team Meeting, on 4/2/13; o IMT meeting, on 4/2/13; and o Residences #511, #514, #515, #517, #522A, #522C, #524B, and #524D, and the Comfort Zone day program.
	Facility Self-Assessment: The CCSSLC Self-Assessment indicated the Facility was in substantial compliance with 18 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 18 of the 22 as well. To conduct the self-assessment, the Incident Management Coordinator reviewed the specific requirements of each provision and any separate elements within the provision by examining files, drawing samples, and visiting residences. There was no reference in the Self-Assessment to the use of the Quality Assurance Monitoring Tool, although references were made to sampling of documents that corresponded to the Quality Assurance sampling matrix. The application of the tool and the resulting comparisons of scores between the IMC and the QA Program Compliance Monitor would have offered authentication to the IMC's results or highlighted areas where additional work was needed. In addition to the Self-Assessment, the Action Plans were reviewed. The Action Plans described action steps related to each provision of the Settlement Agreement and they continued to address some important issues, such as policy revisions. However work was still needed to reach the more difficult issues of

	implementation. For example, for Section D.2.h, which required mechanisms to prevent retaliation, the actions steps included displaying "Zero Tolerance" posters and assuring their replacement as needed, monitoring Unusual Incident Reports (UIRs) for evidence of retaliation, and reporting any identified instances to the Office of the Inspector General (OIG). What was needed was a description of how the UIRs would be monitored, how often, by whom, and what signs might trigger a report. Section D.3.i required the implementation and tracking of actions taken to address disciplinary or programmatic changes and the outcomes of those actions. The initial action steps focused on getting all recommendations into the tracking log in the UIR reporting system. The next steps addressed follow-up on those recommendations that were not completed with the IMT at daily meetings. Additional steps were needed to revise those that were implemented, but not successful and to determine the effectiveness of the changes. The Facility provided the CCSSLC Provision Action Information. This document was designed to review the status of each provision of the Settlement Agreement since the first monitoring report with space to highlight current efforts to come into compliance. Review of the document for Section D found it included multiple entries, providing a clearer view of the activities engaged in to achieve compliance than during previous reviews.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in substantial compliance with 18 out of 22 provisions of Section D, as opposed to the 15 provisions that were in substantial compliance during the last review. Progress was noted in a number of areas. Highlights of that progress included: ▪ The Facility's use of supervisory forms for reviewing UIRs and sending them back to investigators for correction appeared to be in consistent use and demonstrating results; ▪ New posters for alerting individuals to their rights and staff to the need to prevent abuse were in place; and ▪ The annual ISP planning meeting for an individual during the week of the site visit included a discussion of incidents over the past year. Some of the areas in which improvements were necessary for the Facility to progress towards substantial compliance with the Settlement Agreement included the need to: ▪ Address the problem with timeliness of completion of Unusual Incident Reports; ▪ Develop and implement a semi-annual audit of injuries; ▪ Provide for follow-up on recommendations from investigative reports, and document them to conclusion, including a check to assure that the desired outcome has been achieved; ▪ Expand the analysis and trending of data to determine where corrective action plans might be needed to address emerging trends in abuse/neglect findings; and ▪ Resume the use of the Section D monitoring tool in cooperation with the Quality Assurance team or adopt a new one. This joint monitoring effort will help to assure that the details needed to meet and sustain compliance are objectively reviewed and assessed.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Based on an agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. CCSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result the Facility was found to be in substantial compliance with this provision.	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 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.	There were no changes to Facility policy and procedures with regard to incidents or allegations of abuse/neglect/exploitation. However, in the Monitoring Team's last two reports, it was noted that a clearer explanation was needed of what form a report about an unusual incident was to take (i.e., phone call, a written report, or whatever was expected). This remained unclear. However an Action Plan was in place to review and revise Policies D.2 and DD.5 to indicate that the report of an unusual incident was to be made to the Director or Designee by phone. The projected completion date was 3/31/13. Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		According to Facility data provided in the response to the document request III.16.a-e, the following represents the numbers of serious incidents that occurred at the Facility since January 1, 2011:	

Incident Type	1/1/11 to 12/31/11 (12 months)	1/1/12 to 12/31/12 (12 months)
Deaths	8	14
Serious Injuries	22	11
Sexual Incidents	14	8
Suicide Threat (credible)	2	2
Unauthorized Departure	8	2
Choking	6	8
Other	2	5

According to Facility data provided in response to the document request #III.16a-e, the following numbers of allegations had occurred at the Facility from January 1, 2011 through December 31, 2012.

	1/1/11 to 12/31/11 (12 months)	1/1/12 to 12/31/12 (12 months)
Total abuse allegations*	836	623
Abuse substantiated	98	27
Total neglect allegations*	211	258
Neglect substantiated	33	36
Total exploitation allegations*	1	2
Exploitation substantiated	0	0

**Note that the numbers of allegations refer to the total number of calls received by DFPS, not the number of cases, since multiple reports were received on many individual incidents.*

Based on an interview of 10 staff responsible for the provision of supports to individuals, 10 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

Based on an interview of 10 staff responsible for the provision of supports to individuals, 10 (100%) were able to describe the reporting procedures for other serious incidents.

Two samples of investigations were selected for review. These included:

- Sample #D.1 which included a sample of DFPS investigations of abuse, neglect,

#	Provision	Assessment of Status	Compliance
		and/or exploitation. The case numbers are listed in the Documents Reviewed section above. ▪ Sample #D.2 which included a sample of Facility investigations. Some of these were investigations that had been referred to the Facility by DFPS, while others were investigations the Facility completed related to serious incidents. The case numbers are listed in the Documents Reviewed section above. Based on a review of the 30 investigation reports included in Sample #D.1: ▪ 30 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. One allegations was made a day after the incident when a review of surveillance footage identified the possible abuse. One allegation was made months later when an individual spoke about the incident to a staff member who promptly reported the discussion. Although staff were present for these incidents, neither was confirmed, and, therefore, it appeared there was no duty to report. In half of the allegations the caller (often an individual) did not specify a time for the incident, so there was no way to determine if the report was within one hour. ▪ 30 of 30 abuse reports (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. However, it was not clear whether the reporter made the calls to both the Facility Director and DFPS, since the Director's office was not tracking those calls. Based on a review of five incident reports included in Sample D.2: ▪ Five (100%) showed evidence that serious incidents were reported within the timeframes required by Facility policy. ▪ Five (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format that contained the information necessary for adequate follow-up, as well as tracking and trending of incidents. Based on a review of 35 investigation reports included in Sample #D.1 and Sample #D.2, 30 (100%) contained a copy of the report utilizing the required standardized format. Tracking of timely reporting remained an issue. Since reporting of allegations of abuse can be anonymous and might be made by individuals or citizens outside the Facility, the reporting timeframes cannot be enforced with them. While the Facility should continue its efforts to track reports, the Monitoring Team found them in substantial compliance due to the fact that no instances were found in which a lack of timely reporting was confirmed. The Facility's Self-Assessment found the same.	

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	(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.	At the last review, the Monitoring Team indicated that a revision to Facility Policy D.3 was needed to make it consistent with State Office policy. The Facility had issued an instruction on March 12, 2012 indicating the policy would be revised, and that in the meantime, staff identified as alleged perpetrators would be placed on TWR. The only exception would be when the individual had been identified as making spurious allegations and DFPS had been authorized to conduct a streamlined investigation. In those cases, another option would be to put a monitor in place. The Facility's Action Plan indicated a revision to policy was in process and projected to be completed 3/31/13. While the policy revision had not been completed, an additional memo from the Incident Management Coordinator was issued on 12/10/12, which included a list of individuals identified for streamlined investigations. The list was prefaced by a statement indicating that putting a monitor in place in lieu of placing the alleged perpetrator on TWR would only be appropriate if: ▪ There was no information indicating the allegation had been made by someone other than the alleged victim; and ▪ There was no physical evidence consistent with the allegation. While the procedure explained in the memo set out limitations on when staff accused of A/N/E could be kept on duty, those limitations should be imbedded in Facility policy. Based on a review of 30 investigation reports included in Sample D.1, seven involved chronic callers (individuals identified as making false reports), and three involved allegations judged by DFPS to not meet the requirements for abuse or neglect, and therefore handled as Administrative referrals. In the remaining 20, 19 (95%) of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Investigation #42545453 did not identify the two alleged perpetrators immediately. However, when they did identify them, the report did not indicate both were removed, nor did the Facility Status Tracking Sheet indicate both were placed on Temporary Work Assignment. Based on a review of the five Facility-only investigation reports, staff were not removed from duty pending the results of investigation unless abuse or neglect were suspected. If there was suspicion of abuse or neglect, a report would be made to DFPS and that would trigger removal. Based on a review of 20 investigation files included in Sample #D.1, a total of 19 (95%) showed that staff that had been removed from direct contact were reinstated when the conclusion of the investigation allowed their return to direct contact duties. The one exception was Investigation #42545453, where one alleged perpetrator was not removed. Based on a review the 35 investigations in Samples D.1 and D.2, it was documented that	Substantial Compliance

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		adequate additional action was taken to protect individuals in all cases (100%), by adding counseling, medical treatment, and/or monitoring on the home. Based on the finding that in 95% of the allegations where staff should have been placed on TWR, they were and only reinstated when it was determined the employee posed no risk to individuals, and that adequate additional actions were taken to protect individuals in all cases, the Facility is in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	As indicated in previous reports, the Facility policy on competency-based training of all staff on recognizing signs and symptoms of A/N/E was acceptable as was the curricula. Review of 24 staff records (Sample #C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect prior to working directly with individuals. Review of a list of staff who were delinquent in training (Course Delinquency List for ABU0100) showed that 905 (99%) of staff had completed annual refresher training. Based on interviews with 10 staff: ▪ 10 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ 10 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. Based on the high percentage of staff that completed training on A/N/E, the Monitoring Team found that the Facility was in substantial compliance with this provision. The finding of the Facility in its self-assessment was the same.	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 reporting obligations. The Facility shall take appropriate	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, 24 (100%) had signed annual acknowledgments. A random sample of 10 volunteers listed on the "List of Volunteers" revealed that all (100%) had Acknowledgements on file. According to the Facility Self-Assessment, the Action Plan for this provision had been completed. In addition, the IMC provided check sheets showing that he was checking	Substantial Compliance

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	personnel action in response to any mandatory reporter's failure to report abuse or neglect.	monthly to assure all new staff had signed their forms, and staff who were due to renew their statements had done so. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of zero staff. As a result, the Monitoring Team found the Facility to be is substantial compliance with this provision. The finding of the Facility in its self-assessment was the same.	
	(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 the Facility policy manual, Qualified Developmental Disability Professionals (QDDPs) 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 ISP meeting, and to provide a copy to the individual at the meeting. The QDDP was to describe the process to the individual at the meeting. The ISP Meeting Guide also contained instructions to the QDDP to present the A/N/E guide during the annual meeting and to document that action. In the one annual ISP meeting observed, the individual was presented with a copy of the guide, and the family member was mailed a copy. In the Monitoring Team's previous reports, the findings related to the review of the A/N/E Guide, used to educate individuals and families about their rights with regard to reporting was discussed. It was found to be adequate. Based on a review of seven individuals' ISPs (Sample #D.4), seven individuals, or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. In interviewing a sample of 10 individuals, who were able to converse, 10 were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. A review was not conducted of serious incidents reported by individuals, their LARs, or others who were significantly involved in their lives, since there was not information about such reports available. The Monitoring Team the Facility to be in substantial compliance with this provision, as did the Facility Self-Assessment.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and	According Section D.20 of Facility policy and procedure manual, all residences and day programs were to have the "Rights Poster" on display.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The Facility had revised and renewed its posters. The new poster 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 the living units and day programs on campus showed that nine (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Monitoring Team found the Facility to be in substantial compliance with this provision. This was consistent with the Facility's finding.	
	(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 would then notify the appropriate law enforcement authority. Based on a review of 30 allegation investigations completed by DFPS (Sample #D.1), in 20 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 20 (100%). Based on a review of five investigations completed by the Facility (Sample #D.2), there was one for which a referral to law enforcement was necessary/appropriate. The Facility had made a referral in one (100%). Based on this review, referrals were being made to law enforcement and to the OIG on a regular, as-needed basis. The Monitoring Team found the Facility in substantial compliance with this provision. The Facility had made the same finding in its Self-Assessment.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in	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 was prohibited. These individuals could immediately report any alleged incident of retaliation to the Facility Director or his designee. Phone numbers for other reporting alternatives also were provided in the policy. Based on interviews with the Facility Director, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ If the Assistant Director of Programs received a report of retaliation, he forwarded it to the Office of the Inspector General. ▪ OIG would respond as to whether they would investigate.	Substantial Compliance

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	an appropriate or timely manner.	Based on Sample #D.1, it was clear that some individuals made allegations of abuse with no fear of retaliation, and there were no indications in the investigation reports of a concern with retaliation. A list of staff that reported they had been retaliated against for good faith reporting of abuse was requested, and there were no names provided (Document Request #III.28). 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. No names were provided (Document request #III.29). The following describes actions that were taken in an attempt to prevent such retaliation in the future: ▪ Posters reminding staff that retaliation would not be tolerated were displayed throughout the Facility; ▪ Training emphasized the Facility's position on retaliation; and ▪ The stated practice was that any allegations of retaliation were referred to the OIG. Ten staff were asked to anonymously rate their confidence that retaliation for reporting of abuse would not be tolerated. The rating was based on a scale of 1 to 10, when one was the least confident and 10 the most. The average score was 8 and the range was from 4 to 10. The 10 staff interviewed appeared to understand the method for reporting possible retaliation and knew there were posters with numbers to call. All indicated they would not hesitate to report abuse if they suspected it was occurring. In interview and in the evidence section of the Presentation Book for Section D, the IMC noted that staff members sometimes indicated they had been the victim of a false allegation or retaliation. However, these instances were found to be due to a personal or work-related issue and not to their good faith reporting of an allegation of A/N/E. Since the Facility had measures in place to prevent retaliation, procedures to handle any reported retaliation, and no indications were found in sample cases of possible retaliation taking place, the Monitoring Team found the Facility in substantial compliance with this provision. The Facility's self-assessment reported a consistent finding.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	A new state process for conducting the audits was available at the time of the site visit, but had not been implemented. The Monitors have presented the State with their comments on the process. When the Facility implements the process, the Monitoring Team will conduct a review of it.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 to Section DD.1 of the CCSSLC Policy and Procedure Manual, all staff responsible for 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 Monitoring Team previously reviewed the curricula for the Facility and the DFPS investigators, and generally determined it was adequate. In response to a document request, a list of five DFPS investigators with their hire dates and courses completed, their training transcripts, and a crosswalk to the titles of courses, which had changed over time, were provided. The training records for these investigators were reviewed with the following results: ▪ Five of the five (100%) DFPS investigators whose names were provided had completed the requirements for investigations training. ▪ Five of the five (100%) DFPS investigators whose names were provided had completed the requirements for training regarding individuals with developmental disabilities. ▪ A review of the Sample #D1 revealed that all (100%) investigations in the sample were completed by trained investigators. CCSSLC staff with responsibilities for conducting Facility investigations included the Incident Management Coordinator, who oversaw the investigations at the Facility, three full-time investigators, and four Campus Administrators, who reported to the IMC, and who could be called upon to assist in investigations when needed, or to carry out	Substantial Compliance

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		investigations on the second or third shifts, for a total of eight staff. However, one of these staff had not completed any investigations in the sample. A review of the investigators who conducted the investigations in Sample #D.2 indicated that all (100%) had been conducted by one of the investigators listed as trained. The training records for these investigators were reviewed with the following results: ▪ Seven out of seven Facility investigators (100%) had completed the requirements for investigations training. ▪ Seven out of seven Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. ▪ The IMC had completed all required training. A review of the investigators who conducted the Facility investigations that corresponded to the DFPS investigations in Sample #D.1 indicated that all had been conducted by one of the trained Facility Investigators. There were no nurses listed as investigators. In the two investigations in Sample #D.2 that involved deaths, the QA nurse was involved in gathering and reviewing records, but did not sign the investigation as the preliminary or the final investigator. This appeared to be a use of nurses as experts to review documents and provide opinions. However, if nurses are to act as investigators, they should be trained as investigators. The Monitoring Team found the Facility to be in substantial compliance with this provision, as did the Facility.	
	(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 its investigation. The Facility and DFPS held regular quarterly meetings to discuss their respective roles. Minutes were available from the meetings in July 2012, October 2012, and January 2013. Review of the investigation files in Sample #D.1 showed that in 30 out of 30 investigations (100%), Facility staff cooperated with DFPS investigators. The Facility was found to be in substantial compliance with this provision. The Facility Self-Assessment found the same.	Substantial Compliance
	(c) Ensure that investigations are	The Memorandum of Understanding, dated 5/28/10, provided for interagency	Substantial

#	Provision	Assessment of Status	Compliance
	coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	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 of Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 30 the investigation records from DFPS (Sample #D.1), 20 had been referred to law enforcement agencies. For 20 out of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the five investigation records from the Facility (Sample #D.2), one had been referred to law enforcement agencies. For that one (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. The Monitoring Team found the Facility was in substantial compliance with this provision, as did the Facility.	Compliance
	(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. Video surveillance tapes were maintained inside the locked video surveillance room. 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 in 30 out of 30 (100%) DFPS investigations; and	Substantial Compliance

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		▪ Evidence that needed to be safeguarded was in five out of five (100%) Facility investigations. A policy on handling evidence was in place, video surveillance footage was being properly identified and preserved, and staff were following the policy. The Monitoring Team found the Facility to be in substantial compliance. Similarly, the Facility's Self-Assessment showed it was in compliance with this provision.	
	(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 Director 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: ▪ 30 out of 30 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. ▪ 27 out of 30 (90%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. o For the three that were not completed within 10 days, three (100%) 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. ▪ 30 (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	Noncompliance

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		D.3.f of the Settlement Agreement. ▪ In five of the investigations reviewed, recommendations for corrective action were included. In four of the five investigations (80%), the recommendations were adequate to address the findings of the investigation. o In investigation #42536961 the allegation of sexual and verbal abuse were determined to be unfounded. However, the individual had a history of making unfounded accusations and a recommendation to the Facility to further investigate whether programs to address this would have been in order. The Facility UIR did address the issue of repeated calls in its recommendation. <u>Facility Incident Investigations</u> When DFPS conducts investigations, the Facility files an Unusual Incident Report that starts when the call of an allegation is received, gathers documents on behalf of the DFPS investigator, makes notifications, takes steps to assure the safety of the individual, documents its actions in the UIR, and defers any interviews until DFPS has completed its investigation. When the final report is received from DFPS, the Facility reviews that report, incorporates portions into the UIR, adds information from any additional interviews it conducts, reviews any recommendations and logs them into the report for tracking. The Facility also determines if additional information is needed and may refer the report back to DFPS for additional investigation. The Facility has 10 days from the receipt of the DFPS report to conclude the UIR. A review of the UIRs associated revealed no problems with commencing the investigations timely and no problems with producing written reports with summaries of the findings. However there were a number of problems with completing the reports within the 10 allotted days. ▪ Five of 30 UIRs (17%) were completed within the 10 days of the conclusion of the DFPS report. Most were out of date by weeks. Some were incomplete because they did not have dates for the signatures of the IMC and the Director to show when they were complete. ▪ Of the 25 UIRs that were late, none (0%) had extensions of time requested and approved. ▪ In 12 UIRs, the Facility echoed the recommendations of DFPS and/or made additional recommendations, usually related to administrative matters, such as the IDT should follow-up on reports of abuse. In two cases, the Facility did not include recommendations that were needed: o Investigation #42549539 (13-103) included a DFPS concern that an individual was transported to CCSSLC from jail and admitted without a search. He was found to have had eight to nine pills in his pocket, which he managed to put in his mouth out-of-sight of his staff and swallow.	

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		The response to the recommendation was that there was no Facility policy requiring such searches. However, in light of this experience, there should have been a recommendation to consider procedural steps to assure that individuals returning from jails do not bring contraband with them. o Investigation #42637551 (13-194) was an administrative referral from DFPS. One of the facts that emerged from the Facility's investigation was that the individual's mattress was too short for her bed and might have contributed to her injury. There was no recommendation that the mattress be changed or any explanation as to why it could not be changed. <u>Facility-Only Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Five out of five (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ None out of five (0%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. o For the five that were not completed within 10 days, none (0%) had documentation of a written extension request that had been approved by the Facility Superintendent, and/or documentation of the extraordinary circumstances that necessitated the extension. ▪ Five (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 four of the five investigations reviewed, recommendations for corrective action were included. In the fifth, no recommendations were necessary. In four of the four investigations with recommendations (100%), the recommendations were adequate to address the findings of the investigation. In one of the four investigations where recommendations were made, Facility investigation #13-034 reviewed the death of an individual who had broken her arm while being lifted in an Arjo lift. The investigation reviewed the death that occurred at the hospital and made recommendations with regard to procedures. However the investigation did not cover the incident in the lift that resulted in the broken arm that was the reason for the hospitalization. The list of investigations conducted by the Facility (III.21 of the document request) included investigation #13-032 on 9/30/12, the	

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		date of the serious injury, leading to the possibility that the serious injury was investigated separately. That would have been an acceptable procedure. However, that investigation of an injury needed to be referenced in the investigation of the subsequent death. A finding of noncompliance has been made. The Facility's Self-Assessment included a finding of noncompliance. The main issues were the completion of Facility Unusual Incident Reports within the specified timeframes, and the metric for DFPS recommendations was below 90%.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the	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; ▪ The report utilize 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 recorded in an electronic system with screens to capture the required format of the report. 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 30 out of 30 investigations reviewed (100%), the contents of the investigation	Substantial Compliance

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	investigator's reasons for his/her conclusions.	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 30 (100%), each serious incident or allegation of wrongdoing;
		o In 30 (100%), the name(s) of all witnesses;
		o In 30 (100%), the name(s) of all alleged victims and perpetrators;
		o In 30 (100%), the names of all persons interviewed during the investigation;
		o In 30 (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 30 (100%), all documents reviewed during the investigation;
		o In 30 (100%), all sources of evidence considered.
		o Based on the Monitoring Team's review of the DFPS report in conjunction with the Facility UIR, it appeared that in 29 (97%) previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency were reviewed, and as appropriate, addressed in the report. Investigation #42536961 (13-074) had an extensive list of previous unfounded allegations of abuse, which were included in the Facility UIR. However, DFPS did not comment on the possibility that the programs designed to teach the individual alternatives to false reporting were not working and needed revision.
		o In 30 (100%), the investigator's findings.
		o In 30 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of Facility-only investigations:
		▪ In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o In five (100%), each serious incident or allegations of wrongdoing;
		o In five (100%), the name(s) of all witnesses;
		o In five (100%), the name(s) of all alleged victims and perpetrators;
		o In five (100%), the names of all persons interviewed during the investigation;
		o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In five (100%), all documents reviewed during the investigation;
		o In five (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and	

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		perpetrator(s) known to the investigating agency. However, it was not clear whether the Facility was routinely including the list of previous investigations that involved the alleged perpetrators in every case. It is possible that there were no previous allegations involving any of the alleged perpetrators in the sample, but it seems unlikely. Given that the Monitors had modified the requirements in this regard, including using this information as part of the process for measuring DFPS' compliance with this same requirement, in order for the Facility and DFPS to maintain a compliance finding in this area, the Monitoring Team is making a mandatory recommendation that the Facility include a list of all previous investigations for at least the past two-year period, unless a reasonable justification is provided for not including all of them, for the alleged perpetrators as well as the alleged victims in each UIR. o In five (100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. Based on the Monitoring Team's review of investigations, although the Facility remained in substantial compliance with this provision, a mandatory recommendation has been made with which the Facility must comply to maintain its substantial compliance status in the next review. Specifically, as noted above, the Facility must include a list of all previous investigations for at least the past two-year period, unless a reasonable justification is provided for not including all of them, for the alleged perpetrators as well as the alleged victims in each UIR related to abuse, neglect, and exploitation. The Facility's Self-Assessment also found substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of CCSSLC Policy #002.2 and the associated procedure DD.11, it required staff supervising the investigations to review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. The policy required that any further inquiries or deficiencies be addressed promptly. 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. <u>DFPS Investigations</u> To determine if supervisors had reviewed investigations, the Monitoring Team checked for an electronic sign-off by the supervisor and the Facility's UIR report for any concerns	Substantial Compliance

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		raised. If the signature was present, the Facility UIR did not raise concerns, and there was at least 90% compliance with the requirements of D.3.e (excluding timeliness) and D.3.f, the investigations were found to be in substantial compliance. The following summarizes the results of the review of DFPS investigations: ▪ In 27 out of 30 investigation files reviewed (90%), there was evidence that the supervisor had conducted a review of the investigation report. There were no supervisor entries on the three Administrative Referrals in the sample. ▪ For the 30 investigations, there was no evidence that the UIR had resulted in returns of DFPS reports for changes to be made to correct deficiencies or to complete further inquiry. ▪ As noted above, at least 90% compliance was achieved for the DFPS investigations for Sections D.3e (excluding timeliness) and D.3.f. <u>Unusual Incident Reports</u> The following summarizes the results of the review of UIRs conducted in conjunction with DFPS investigations: ▪ In 30 out of 30 investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In three (10%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. In one (13-240), the supervisory note instructed a change be made to document notification of the State Office and it did not appear that change was made. ▪ For the two investigations for which the Monitoring Team identified deficiencies, the supervisory review did not appear to address these deficiencies. These investigations were: o Investigation #42549539 (13-103) where the supervisor did not give any instructions about the need to recommend a new mattress; and o Investigation #42637551 (13-194) where the supervisor did not recommend a review of policy or procedures to address the need for searches for contraband of individuals coming from jail. As a result, for 28 out of 30 (93%), it appeared the review was sufficient to identify relevant issues. <u>Facility-Only Investigations</u> The following summarizes the results of the review of Facility-Only investigations: ▪ In three out of three investigation files, submitted as part of the sample reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. Two of the reviewed cases were submitted on site, and the Monitoring Team's request did not specify inclusion of the supervisory note, so these were not included in this finding. ▪ In one of the investigations no changes were needed. In two of the two (100%)	

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		there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The Facility had a process in place for review of investigations by the IMC as evidenced by the adoption of the form and its inclusion in all but the two reports gathered on site. DFPS reports included a supervisor's signature, and while no notes were provided related to issues identified and addressed with investigators, the Facility was reviewing the DFPS reports and including comments in the UIR, and there were no requests for changes or further investigation noted. In addition, the DFPS investigations were found to meet the quality requirements by at least 90%. The Facility was found to be in substantial compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed with regard to Section D.3.f above. For this provision, implementation of the mandatory recommendation is necessary for the Facility to maintain a substantial compliance rating for the next review.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	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. Facility Policy D.14, entitled Participating In and Completing Review Authority Team, revised on 5/22/11, designated the Review Authority Team to review all final DFPS reports and make recommendations to the Director for approval. The responsibilities of the Team also included follow-up tracking of all recommendations made by the Team. The policy provided a format for making recommendations, and prescribed a method for tracking the recommendations in the Incident Management Team minutes, and recording them in the investigative report. CCSSLC's Action Plan for this provision specified five steps to accomplish the tracking and documentation. According to their Action Plan status, three steps had been completed: to evaluate concerns and recommendations in the reports, to add any recommendations from the Facility investigators, and to ensure that Review Authority Team recommendations were entered into the Recommendation Tracking Log. Two steps remained: to address any recommendations that were not completed, and to revise recommendations that were implemented but unsuccessful. The target dates for the remaining steps were 7/31/12 and 12/31/12, respectively. In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2, were selected	Noncompliance

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		for review. The investigations in the subsample (Sample #D.6,) are listed in the Documents Reviewed section of this report. Documentation was requested to show what follow-up had been completed to address the recommendations resulting from these investigations. In addition, while the Monitoring Team was on site, some observations and interviews with staff were conducted to determine if adequate follow-up had occurred for some of the investigations included in the sample. For two out of six of the investigations reviewed, disciplinary action was recommended. In both cases (100%), prompt and adequate disciplinary action had been taken and documented (i.e., #42550611 and #42630015). For two out of six of the investigations reviewed, programmatic action was recommended. Neither (0%) documented that prompt and thorough programmatic action had been taken. More specifically: ▪ For Investigation #42549539, DFPS documented a concern that an individual had been returned from jail, secreted pills in his clothing, and managed to swallow them, necessitating emergency treatment for a possible overdose of an unknown substance. The Facility response was to indicate that there was no Facility policy on searching returnees from jail, without consideration of whether there should have been a policy. ▪ For Investigation #42552898, the Facility investigator recommended in-servicing of a staff member on the need to conduct a medical assessment upon receipt of an allegation of abuse or neglect, and in-servicing of the IDT on the need for the team to review a report of abuse or neglect for possible changes to the individual's ISP. There was no documentation that this had been done. For two out of the two Facility investigations (i.e., #13-036 and #13-071), where there were recommendations imbedded in the narrative, actions had been taken, but those actions were not recorded in the UIR tracking section. As a result, there was no documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic actions. As a result of the identified issues with documentation and tracking of recommendations and desired outcomes, The Facility was not in substantial compliance with this provision. The Facility's Self-Assessment contained a similar finding which it planned to address through Action Plan D.3.i.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and	Section DD.5.2 of the Facility Policy manual 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 Incident Management office, and were readily available to investigators and other appropriate personnel.	Substantial Compliance

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	other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Electronic copies of Unusual Incident Investigation Reports were entered into the electronic AVATAR system. This allowed access to investigators without need to pull the paper files. Electronic copies of DFPS final investigation reports with supporting documentation were maintained in a shared drive of the Facility computer system. This allowed access to investigators without need to pull paper files. Based on the Monitoring Team's review, the Facility remained in substantial compliance. The Facility's findings in its Self-Assessment were consistent with this finding.	
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 Assurance 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. The Facility had discontinued the practice of reporting the names of staff involved in allegations in its monthly Trend Reports, which circulated within the Facility, but retained the names in the electronic files. In this way, the names were available for review to selected staff that could analyze them. However, there was no indication that trending was being done on an ongoing basis. The Facility provided tracking and trending reports for incidents and allegations for months from October 2012 through January 2013. Each report showed the number of incidents or allegations by month with breakdowns of the data for the month by: type, individuals involved, location, date/time, cause, and outcome. Beginning in September 2012, charts were added that displayed longitudinal (one year) data on individuals, by home and by investigation outcome. The charts and graphs included trend lines to show how allegations or incidents were changing over time, but they did not provide an analysis of what the changes might mean and whether programmatic or systematic changes might be needed. While the information in the report was useful, it did not provide complete trending of data as required by this provision. The Action Plan for this provision included revising current local policy regarding use of databases for trend reporting, production of a complete trend report to be shared with the IMRT on a monthly basis, and the implementation of corrective action plans to	Noncompliance

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		address issues identified in the Trend Reports. The policy should include sharing the report with the QA/QI Council as well. The Facility's Self-Assessment indicated that the Facility was not yet in compliance with this provision. This was consistent with the Monitoring Team's findings. While there was progress in use of longitudinal graphic displays of some data, additional analysis was needed. Because the Facility's current trend reports did not include trending (i.e., analysis) of the specified data over time to allow the Facility to determine the need for corrective action and/or implementation of such corrective actions, the Facility had not met the requirements of the Settlement Agreement.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. 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 2012. 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 no one had been terminated for failure to self-report, although the Facility's Self-Assessment indicated one of the 963 employees had been terminated.	Substantial Compliance

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		In an interview with the Facility Director, his decisions regarding the employment reportedly occurred on a case-by-case basis. Based on general responses to questions about this duty, it appeared his decisions were based on the facts and were mindful of his responsibility to safeguard the individuals and staff of the Facility. The Facility remained in substantial compliance with this provision. The Facility's finding was the same.	

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

1. When an incident is reported to the Incident Management Unit whether by DFPS or by someone else, the date and time should be recorded in the UIR. If it was reported to DFPS and to the Incident Management Unit, both should be recorded to help establish that staff are following the rule about reporting to both. (Section D.2.a)
2. The Facility's Action Plan with regard to Section D.2.i should be revised to indicate how the Facility intends to review all injuries every six months, and report for investigation those injuries that due to frequency or other criteria raise suspicions of possible abuse or neglect, if reports have not already been made. Once the new State procedures are finalized, then the Facility should implement the policy. (Section D.2.i)
3. A system for timely completion of unusual incident reports should be adopted and should include dating of signatures on the review section of the URI so that it can be determined when the IMC and the Director signed the reports. (Section D.3.e)
4. **Mandatory Recommendation:** The Facility must include a list of all previous investigations for at least the past two-year period, unless a reasonable justification is provided for not including all of them, for the alleged perpetrators as well as the alleged victims in each UIR related to abuse, neglect, and exploitation. (Sections D.3.f and D.3.h)
5. The UIR should contain documentation of when any recommended actions were completed, and reference documentation in the file that demonstrates that completion. When recommendations involve observable outcomes, such physical changes to an individual's residence, or specific retraining for staff, the Campus Administrator should confirm the changes or training during their rounds and produce their notes as evidence for the file. (Section D.3.i)
6. The Facility should finalize its tracking and trending system. (Section D.4)
7. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or corrective action plans developed to address any underlying causes of trends identified. (Section D.4)

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003.1: Quality Assurance, dated 1/26/12; o CCSSLC Procedure #R.13 MAPES: Incident Trend Analysis, revised 10/26/09; o CCSSLC Self-Assessment, dated 3/18/13; o Presentation Book for Section E; o CCSSLC Quality Assurance Plan, undated; o Data Collection at CCSSLC, dated 3/27/13; o Corrective Actions Plans, provided in response to Document Request TX-CC-1301-IV.7; o CCSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, for 1/1/13 to 1/31/13; o CCSSLC Trend Analysis Report: Injuries for 1/1/13 to 1/31/13 and 12/1/12 to 2/28/13; o CCSSLC Unusual Incidents Trending Report for 1/1/13 to 1/31/13, 9/1/12 to 11/30/12 and 12/1/12 to 2/28/13 o CCSSLC Restraints Trend Analysis Reports for 1/1/13 to 1/31/13 and 12/1/12 to 2/28/13; o CCSSLC Dental Services Quarterly Trending Report: 9/1/12 to 11/30/12; o CCSSLC Council/Quality Assurance/Quality Improvement (QA/QI) Council meeting notes, dated: 9/13/12, 9/20/12, 9/24/12, 9/27/12, 10/12/12, 11/1/12, 11/8/12, 11/16/12, 11/29/12, 12/6/12, 12/14/12, 12/20/12, 1/4/13, 1/10/13, 1/17/13, 1/24/13, and 1/31/13; o CCSSLC Council/Quality Assurance/Quality Improvement Council meeting agenda and handouts for meeting on 4/4/13; o Quarter 4 (Q4) Safety Committee Minutes: dated 8/28/12; 11/27/12; o Injury Trend and Analysis Meeting Minutes: 10/16/12; o QA/QI Committee/Workgroup: Individuals hitting staff; o Monitoring tools associated with the Quality Assurance Plan; o QA/QI Data Summaries for: ▪ Section C: 1/10/13 (QA/QI minutes) ▪ Section D, 9/24/12 (no data) and 12/14/12; ▪ Section E, 9/24/12 (no data), 12/14/12; ▪ Section F, 11/27/12 and 12/5/12; ▪ Section I, November and December 2012 ▪ Section J, May to November 2012; ▪ Section K: 1/10/13, ▪ Section L: FY12, Quarters 2 and 3; ▪ Section M: 9/24/12, and 12/14/12; ▪ Section O: November and December 2012; ▪ Section P: November and December 2012; ▪ Section Q: 9/24/12; ▪ Section R: November and December 2012;

	▪ Section S: November 2012; 12/14/12, and 12/20/12; ▪ Section T: 9/24/12, and 12/14/12; ▪ Section U, November 2012; ▪ Section V, November and December 2012, and January 2013; ▪ Internal Medical Audit: not found; and o Individual Support Plans for Individual #38, Individual #141, Individual #79, Individual #310, Individual #179, Individual #359, and Individual #252. ▪ **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Cynthia Velasquez, Quality Assurance Director; o Jon Breseman, Incident Management Coordinator; o Kristina Sheets, Director of Residential Services; o Polly Ramirez, Settlement Agreement Coordinator; o Program Compliance Monitors (PCMs); and o Various staff in residential units, including ten Direct Support Professionals. ▪ **Observations of**: o QA/QI Council Meeting, on 4/4/13 o Atlantic Unit Team Meeting, on 4/2/13; o IMT meeting, on 4/2/13; and o Residences #511, #514, #515, #517, #522A, #522C, #524B, and #524D, and the Comfort Zone day program.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools as a basis for the Self-Assessment, or if the tool was used, it was not referenced. ▪ Did not use other relevant data sources and/or key indicators/outcome measures. Instead the self-assessment was based on a review of documents, such as meeting notes without reference to dates, frequencies of performance, or any data-based assessment of performance. For example: o Section E.1.2 called for a review of the data inventory lists to determine if they outlined the tracking and trending of all data related to Facility practices. The result indicated that Unusual Incident data, A/N/E data, and injury data was being tracked. There was no assessment of the data for any other sections of the Settlement Agreement and no explanation for why other data should not be tracked and trended. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Did not present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items.

	▪ The Facility rated itself as being in compliance with none of the sub-sections of Section E. This was consistent with the Monitoring Team's findings. ▪ Some of the Facility data identified areas of need/improvement. For example: the incident data indicated most incidents occurred in the bedroom. This suggested the need to ask the question "why," and to determine what might be done systemically to change that pattern. A large number of unfounded allegations of abuse were made by a small number of individuals. A history of making false allegations could impede an individual's community placement prospects, since community services do not take false allegations lightly. This suggested that a number of disciplines could collaborate in working with these individuals to help them become reliable reporters. The Facility provided Action Plans for Section E. All of Section E.1 action plans were reported to be completed. However, some, such as developing a set of key indicators and implementing data collection did not appear to have been done. The Section E.3 action step for modifying the Corrective Action Plan (CAP) tracking log to include information regarding the date of the dissemination of CAPs was marked completed, yet there was no evidence that it was in use. While there was a note in the Presentation Book to indicate the tracking was captured in emails, the log presented did not appear to include tracking of dissemination.
	Summary of Monitor's Assessment: Since the Monitoring Team's last visit, the Monitoring Teams jointly submitted to the State a protocol and metrics for assessing compliance with the Settlement Agreement for Section E. This report assessment has been completed using the new method. Since the Monitoring Team's last review, the Facility had made some progress with regard to Section E, including: ▪ Changes in the assignments of Program Monitors to sections to bring fresh eyes to various sections of Settlement Agreement monitoring; ▪ A data inventory was available, providing a useful tool to quality assurance and the disciplines; ▪ There was an increase in the number of CAPs; ▪ The QA/QI Council adopted a new schedule for reviewing the performance of each section; and ▪ Several workgroups had been established by the QA/QI Council to address specific concerns and to complete CAPs where indicated. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ It was not clear how the data generated by the QA Monitoring tools would be used in preparation of the Facility Self-Assessment. The source and reliability of data used in the self-assessment needs to be identified in order to be helpful in determining if the Facility is in substantial compliance; ▪ Not all sections had a QA monitoring tool and were using it. Some sections were using tools that they indicated needed changes to be useful. It will be important to adopt and use tools that provide meaningful data that in aggregate will allow decisions to be made about system change and about how to identify and support individuals with substantial issues; ▪ Work was needed on the QA Plan narrative to include its purpose and to append the Matrix and the Data Inventory;

	▪ The Facility needs to produce a list of CAPs that are based on data analysis, include measurable outcomes, and are designed to make important changes; and ▪ Departments and disciplines need to identify key indicators of performance and monitor progress.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	<u>State QA policy</u> There was a State policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the State policy, entitled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: ▪ It seemed to have reserved policies for statewide development, and procedures for Facility development. This will keep the terminology consistent and the Facility should not have to re-label the State policy to adopt it. ▪ It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. ▪ The policy language was simple and straightforward and the bullet style will make it easy for staff to read. ▪ It required disciplines to keep account of their databases and the QA Department to keep track of all databases. Other comments: ▪ The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the Facilities to have procedures to deal with both. ▪ There did not appear to be a list of key indicators or a directive to develop a list. ▪ The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State Office should consider this. <u>Facility QA policies</u> There were no Facility policies and procedures related to quality assurance beyond the State policy as noted in the Documents Reviewed section of this report. There needs to be a Facility procedure regarding the data inventory as described below, as well as any additional policies or procedures necessary to operationalize the State Office policy. <u>QA data list/inventory of data</u> The Facility maintained a data list that identified data for most sections of the Settlement	Noncompliance

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		Agreement that could be used to identify trends related to the requirements of those provisions. All data on the list included a description. Those sections for which data was not identified included: ▪ Section S: day services did not appear to have any data listed on the inventory; ▪ Section F: the data list included information on IDT meeting attendance, tracking of assessments by discipline, a calendar of meetings, and tracking of daily incidents. It did not identify data related to the specific activities of the IDTs, including, but not limited to dates of amendments to ISPs, reviews of the ISPs, or progress on SAPs, which would be needed to track compliance with the Settlement Agreement. ▪ Section E: Quality Assurance: the data inventory lists "all tools listed on this document." If that statement referred to the various auditing tools used by program monitors and section leaders, then that data was accounted for. However, since those tools change, the list would be more accurate if it referenced each of the tools individually. ▪ The data list/inventory did not include data on key indicators (outcome and process) of performance, selected by the QA/QI Council to track priorities. No key indicators had been identified for any of the sections of the Settlement Agreement. The data inventory included data from: disciplines/departments, areas of care, protections and supports. It appeared that most of the data collected could be reported according to program areas, living units, work shifts, and individuals. The Facility should specify which data could be reported across the various areas, units, etc., and include that information on the data inventory. There did not appear to be any Facility policy or procedure with regard to creating and maintaining a data inventory or how often it should be updated. The Facility provided a data inventory, arranged by section of the Settlement Agreement as of 3/27/13. Upon interview, it appeared that the list was updated as new requests for reports or additional data screens were put in place, but there did not appear to be a requirement that the list be updated every six months. A positive feature of the data inventory was the inclusion of numerous reports that had been designed and were ready for use to assist with analysis of Section C (Restraint) data. A review of some of the screens that could be used to generate these reports indicated that they were user-friendly, making it possible for staff in the Behavioral Services Department to easily access numerous analytical reports. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was not dated and it could not be determined if the QA plan had been reviewed and revised, as appropriate, within the last 12 months.	

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		The QA Plan described the QA program with regard to the organizational structure of the QA process (including individual roles and responsibilities), but it did not include: ▪ A description of the purpose of the QA program; ▪ A description of how data would be summarized and analyzed; ▪ A description of how key indicators of performance would be determined; ▪ The role of other departments in quality assurance (including QA Department and discipline department collaboration/meetings); ▪ A description of how the QA Department interfaces with quality assurance related committees, such as the Restrictive Practices Review Committee or the Physical Nutritional Management Team; ▪ A description of the QA report, how it will be structured and how often it will be made to the QA/QI Council; ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process; and/or ▪ A description of how corrective actions/CAPs will be tracked. A QA Plan Matrix was available, but it was not appended to the QA Plan. This was true of the data inventory as well. To constitute a complete QA Plan, theses documents should appear together so that anyone reading the plan has a complete picture of the Facility's QA process. <u>QA Plan Matrix</u> For the 20 sections of the Settlement Agreement, a set of key indicators was included for none of the 20 sections (0%). The following metrics could not be assessed due to the lack of key indicators. However, they will be assessed during future monitoring reviews: ▪ Of these ___, both process and outcome indicators were identified for ___ (%) of the sections. ▪ Of these ___, in ___ (%) the indicators provided data that could be used to identify the information specified in E1: trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports. While the Matrix included audit tools for all sections, except E (which had a tool that should be added to the Matrix), it did not specify the number of tools for some sections. For example, Section M had a number of tools that had been reduced to six. The information on the Matrix should include the six separate tools, with the information about who will audit, sample size, etc., so that anyone viewing the Matrix will have a clear picture of the scope of the data collected and so that the Facility can accurately track the submission of data on a monthly basis.	

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		The Matrix would benefit from the inclusion of the Family and LAR satisfaction survey data that had been compiled, as well as the data from employee surveys, individual surveys and business partner surveys that are anticipated to be compiled in the future. <u>Self-monitoring Tools for all Settlement Agreement Provisions</u> The QA plan matrix did not include self-monitoring tools/self-monitoring procedures for the 20 sections of the SA. Tools/procedures were not noted in the matrix for Section E. However, a tool for Section E was provided and had been implemented. The Matrix should be amended to include it. Copies of tools were not provided for sections L, N, Q, and R, although they were listed in the matrix as having tools. A tool was listed for Section D, however, upon interview, it was learned that the tool had not been implemented while work on a revised tool was underway. The Facility should implement the tool while the revision is pending, or adopt the amended tool immediately and resume monitoring. It was learned through interview that the Section M tools had been revised and the number of tools reduced. There was no indication of change on the matrix. The self-monitoring tools that were listed did identify the frequency of monitoring, and the persons responsible for monitoring. However, as noted above, not all tools were listed that were used by various sections. <u>All Data Collected by QA Department</u> Data that QA staff members collected were listed on the matrix, except for survey data. <u>Includes Satisfaction Measures and Follow-up</u> There were surveys of families/LARs at least annually. Surveys of community partners were not available, but drafts of satisfaction surveys for individuals and for employees were presented, although there was not a schedule or process in place for conducting them. The survey for individuals appeared to be a paper and pencil questionnaire, and it was not clear how it would reach most individuals, given that most are not able to read. It was not clear whether follow-up on significant findings were being completed within 90 days. <u>All Items in QA Plan Matrix Also Appear in the QA Data List/Inventory</u> The Facility appeared to have grouped all monitoring tool data under the sub-heading: Section IV - Quality Assurance/Enhancement. The monitoring reports were not listed separately on the data inventory.	

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		All Data in the QA Plan Matrix Were Submitted and Received Of the 19 items in the QA plan matrix, seven (37%) were submitted/collected/received by the QA Department for November and December 2012, based on a review of the data summaries provided in response to Document Request #1301-IV.6. The seven that were submitted were for Sections: F, O, P, R, S, U, and V. Others were included in the submission, where the monitoring was done by the Program Monitor, but not by the section lead or other responsible party as listed on the matrix. For the rest, there was no documentation submitted. Of the 19 items in the QA plan matrix, eight (42%) were documented, based on minutes of QA/QI Council meetings, to show some review or analysis by the QA Department and/or the department section leads for the last two reporting periods for each item (e.g., monthly, quarterly). Those that were reviewed included: C, I, J, K, M, N, O, and U. Others had at least one review, including: D, F, P, R, S, T, and V. While many of the reviews summarized monitoring data, none of the reviews appeared to include a comprehensive analysis of that data such that it could provide guidance in determining what corrective action plans might be needed. QA Staff Assist Disciplines/Departments in Analysis of Data For the 19 sections of the Settlement Agreement (Section E excluded), none had documentation (such as meeting notes) indicating that QA staff had assisted the section leads with analysis, and none had documentation of the reasons that assistance was not needed. Implement the QA Plan as Written (i.e., narrative and matrix) The following metric could not be assessed, but will be assessed during the next review: ▪ Of the components of the QA plan narrative and QA plan matrix, the facility implemented (%). Self-monitoring Tools/Activities for All Sections of Settlement Agreement Of the self-monitoring tools for the 20 sections of the SA, 15 (75%) had instructions for the user. Those five that did not were L, N, Q, R and U. For four of the five that did not, no monitoring tool was provided. Section U had a tool, but did not have instructions. Any comments on the adequacy of the instructions can be found in the specific sections in the report. As the QA Director and the Department section leaders work towards improving the self-monitoring tools, the Facility should be prepared to present to the Monitoring Team the following information on aspects of the self-monitoring tools: 1. Content/validity: A description of how the content of the tools were determined to be valid (i.e., measuring what was important) and evidence that each tool received	

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		a review by QA/QI Council at least twice within the past six months. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, (a) the content of ___ (%) appeared to be appropriate and (b) __ (%) were reviewed within the past six months, and revised as appropriate.) 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. (Metric to be measured: Of the ___ self-monitoring tools for the Settlement Agreement included in the sample, ___ (%) had adequate instructions for the user.) 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. [Metric to be measured: Since the last onsite review, of the self-monitoring tools for the 20 sections of the Settlement Agreement, ___ (%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement).] 4. QA review: A report or summary showing that there was documentation of QA department review of the results of the monitoring, at least once each quarter, for each of the 20 sections of the Settlement Agreement. (Metric to be measured: Since the last onsite review, of the 20 sections of the SA, there was documentation that the implementation (including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for ___ (%) of the 20 sections.) The Facility was not in substantial compliance with section E.1 because the QA Plan, the Matrix and the Data Inventory needed the work described in this report to be complete, the self-monitoring tools needed to be implemented as specified in the matrix, and the results reviewed with the QA/QI at least quarterly.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action	<u>Data and QA Reports</u> To determine if the data from the QA plan matrix had been summarized, graphed and analyzed, a sample was drawn for the months of November and December 2012 from the reports supplied in response to document request #1301-IV.6, which resulted in nine sets of reports. (Sections F, I, J, O, P, R, S, U and V.) Data from the QA plan matrix for these nine sections of the Settlement Agreement were summarized but not graphed showing trends over time or analyzed across a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. Data must be presented over time for a long enough period to permit assessment of trends; graphs need to present data in ways that facilitate analysis; and the analysis needs to occur that results in the identification of common issues and/or underlying causes of those trends or issues. As noted above with regard to Section E.1, little analysis had been completed for any of the sections. Detailed analysis is a key to providing guidance in determining what corrective action plans might be needed. This is	Noncompliance

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	step must occur.	an area on which the Facility should focus. <u>Regular Meetings Between Discipline Department and QA Staff</u> Based on a review of a sample of five of the sections of the Settlement Agreement, (i.e., C, D, F, J, and P), the minutes of meetings between QA staff and discipline heads for the last two quarters did not appear to have been kept, although both the QA Director and the Program Monitors reported they met at least monthly with the section lead for each of the sections monitored. Such meetings should be documented and the minutes should indicate the following: ▪ Review of the data listing/inventory and matrix; ▪ Discussion of the data and outcomes; ▪ Review of the conduct of the self-monitoring tools; ▪ Creation/proposal of corrective action plans; ▪ Review of previous corrective action plans; In future reviews, the Monitoring Team will assess the following metrics: ▪ Since the last onsite review, a meeting occurred at least twice for ___ of the ___ sample (%) sections of the Settlement Agreement, and the five topics (the five topics listed above) were conducted during ___ of the ___ (%) meetings that occurred. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were available to facilitate department/discipline analysis of data. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, data were reviewed a analyzed. ▪ Since the last onsite review, during ___ of the ___ (%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified ▪ In ___ of the ___ meetings (%), recommendations and action plans selected when appropriate to do so, were based on the data presented. Comments should be included on any issues with the conduct of the meetings, the availability of data or the process that led to creation of CAPs. <u>QA Reports</u> Of the 20 sections of the Settlement Agreement, 13 (65%) appeared in a QA report at least or in each quarter since the last onsite review. Those that did not were Sections G, H, L, N, P, Q, and R. Of the sections of the Settlement Agreement that were presented, none (0%) contained the following components: a. Self-monitoring data i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate. b. Key indicators	

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		i. Reported for a rolling 12 months or more; and ii. Broken down by program areas, living units, work shifts, etc., as appropriate. c. Narrative analysis. <u>Facility QA/QI Council</u> There was an adequate description of the QA/QI Council in the QA plan narrative or in a separate QA/QI Council policy or procedure document. The narrative listed the Facility Director as chairing the QA/QI Council and listed the discipline heads and other key members such as the Settlement Agreement Coordinator as members. The narrative provided for additional department staff as necessary to attend or facilitate a discussion. Since the last onsite review, the QA/QI Council met at least once each month. The meeting schedule, reviewed in the minutes of the Council of 1/4/13, included a plan for each section to present quarterly. Minutes from the 18 scheduled meetings of the QA/QI Council from 9/13/12 through 1/31/13 were reviewed. In 17 of the 18 (94%) QA/QI Council meetings documentation indicated that: ▪ Meetings generally occurred according to schedule. There was no record of the October 12 meeting or reason documented for change. ▪ Agendas included topics/presentations related to QA. Attendance/representation as per policy was not always present at these meetings. <u>Data and Analysis Presented</u> Minutes from the 18 meetings reviewed indicated that none of the 18 (0%) documented that ▪ Data from QA plan matrix (key indicators, self-monitoring) were presented; ▪ The data presented were trended over time; and/or ▪ Comments/interpretation/analysis of data were presented. However, while key indicators were not presented, and there were a few presentations of data from the QA Monitoring tools by the QA Director, the Section Leads did sometimes note whether monitoring tools had been used and the degree of inter-rater reliability. It was not clear from the minutes and the attached quarterly section reports whether the monitoring tool data were proving helpful in evaluating progress and designing CAPs. Some sections such as Sections C and D appeared to rely on incident data that was trended over time, graphed, and included some analysis. <u>Recommendations and Corrective Action Plans (CAPs)</u> Two lists of CAPs were presented. One list was arranged by Section and included 51 separate CAPs. The second list was arranged randomly and included 46 CAPs. Neither list was dated, so it was not possible to determine if the lists were current. Looking at the list	

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		by Section, it appeared that each entry was not a separate plan, but rather a step in a larger plan. For example: on the Section C sheet, there were 19 entries with the issue designated as C.4. All appeared to be related to desensitization training. One called for ordering televisions, another for mounting the televisions, another for developing 10 desensitization plans, and another visiting Rio Grande SSLC program. A reasonable reading of these entries would be as steps in a plan to provide for better oral hygiene or better tolerance of dental procedures. As individual plans, these actions did not appear to be related to data or to stand on their own as plans with measurable outcomes for individuals. However, relying on the list of 51 CAPs for purposes of this report: ▪ Of the 51 CAPs presented, 32 (63%) were based (although very loosely) on the data presented; and ▪ None of the 51 CAPs presented addressed both high-risk individuals and systemic issues. Only two of the CAPs (Section V) were clearly based on data. One indicated that historical records were at 36%, and should have been 100%. The other indicated inter-rater scores to be at 60%. At the QA/QI Council Meeting on 4/4/13, there were no presentations of data or plans of correction per the weekly schedule, so it was not possible to see first hand how the Council received presentations, commented on them, and decided whether a CAP was needed. It would be helpful during a future Monitoring Team visits, if the Council could modify its schedule to allow for presentations and CAP development, so that the team could obtain a fuller picture of how this happens. For the next Monitoring Team visit, the Facility should modify its list of CAPs. Each CAP should have a clear connection to data, and should address either systemic issues identified in the data or issues with individuals that emerged from the data. If a CAP has several steps to address a single issue, that should be captured on the list. For example, if the lines related to C.4 are all steps in an action plan, the list might use compliance with C.4 as the issue one time, and the steps in the Actions column might be numbered to show they are part of resolving the one identified issue. <u>System for generating CAPs</u> A written description did not exist that indicated how CAPs were generated. Such a description needs to be included either in the QA Plan or in a Facility Procedure and should include: ▪ Criteria for a CAP; and ▪ A description of how to evaluate indicators for criteria.	

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		CAP development When considering the full set of 51 CAPs, as presented, none (0%) appeared to have been chosen following a written description, policy or procedure since no such written description could be found. Content of each CAP: Of the 51 CAPs reviewed, 32 (63%) appeared to address the specific problem for which they were created. The 19 that did not were listed as C.4 and included entries as CAPs such as "Mount Television in DS Clinic." While this might have been part of a larger plan to create an environment conducive to a relaxed visit to the dentist, it was hard to imagine it as a separate plan, responsive to data. CAPs contain all necessary components A sample of 10 CAPs, representing 20% of the total of 51 CAPs was drawn. The CAPs in the sample, identified by the listing under "Issue" were: 1. Coral Sea 1: Coral Sea has had very poor participation in community integration and completion of community SAPs. Coral Sea residents have not been able to attend group home visits on a regular basis. 2. Coral Sea 3: Coral Sea has had very poor participation in community integration and completion of community SAPs. Coral Sea residents have not been able to attend group home visits on a regular basis. 3. Individuals with placements past 180 days. 4. Historical Records is currently at 36%. It should be at 100%. 5. There is no family and LAR participation in Education regarding living options. 6. Restraint Checklists are not consistently completed, submitted within the timeframe and entered within the timeframe. 7. CIRs contain incomplete/inaccurate information 8. CIRs contain incomplete/inaccurate information 9. N.6 Not getting Adverse Drug Interactions addressed. 10. Residential staff not aware of and/or not following current schedules (11/7/12 due date). It would be useful to number the CAPs as they are approved by QA/QI Council to make referencing them more efficient. Of the 10 CAPS in the sample: ▪ None (0%) included the actions to be taken to remedy and/or prevent the reoccurrence. For example, CAP #7 (from the list above) had one action: "IMC will assemble training materials and set training dates for IDTs at each unit." While this was a step toward training which could help with the accuracy of information, there was no information about what portions/items on the CIR were resulting in the inaccuracies, what form the training would take, or how the anticipated training might produce better results than previous training.	

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		▪ Ten (100%) included the anticipated outcome of each action step, though most did not specify the outcome in measurable terms. For example: "there will be family and LAR participation in education about living options" would be better stated as "Participation by families and LARs will increase from ___ to ___." ▪ Five (50%) included the person(s) responsible by name (1) or by title, and included no more than two people. The remaining (#5, 3, 4, 1, 10) included whole departments or lists of multiple people, making it difficult to determine who was actually responsible. Broad assignments of responsibility do not allow for accountability, which is the purpose for making an assignment. ▪ Ten (100%) included the time frame in which each action step must occur. Based on the limited analyses conducted, unclear linkage between data analysis and the corrective action plans, the lack of clear description of what a CAP needed to include, insufficient action steps in CAPs, the unclear designations of responsibility, and the unclear outcome measures to evaluate the success of the CAPs, the Facility was not in compliance with this provision of the Settlement Agreement.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	To determine compliance with this provision, the Monitoring Team requested the Corrective Action Plan Tracking sheet and compared it to the list of CAPs provided. Based on a sample of 10 CAPs (noted above) which represented 20% of the total of 51 CAPs: there was documentation that indicated: ▪ How each CAP was disseminated, usually via email, in 10 CAPs (100%); ▪ When each CAP was disseminated or to be disseminated in none of the CAPs (0%); ▪ To whom the CAP was disseminated in none (0%) of the CAPs. The Facility needs to describe a clear process for dissemination and the tracking sheet should indicate the how, when, by whom, and to whom for each CAP. The Facility was not in substantial compliance with this provision since it was not clear how CAPs were to be disseminated, and the tracking sheet did not provide the essential information to assure that a basic process was being followed.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	In order to look behind the information provided in the tracking sheet, samples of five CAPs were requested with information about when they were approved, status updates, any changes to the original CAP, and any outcome measurement that was done to assure the desired result was achieved. The sample included: ▪ CAPs #1 and #2: to increase community participation (complete); ▪ CAP #3: to track the time from referral to placement (complete); ▪ CAP #4: to assure all records were converted (complete); and ▪ CAP #5: to assure family and LAR participation (incomplete).	Noncompliance

#	Provision	Protocol	Compliance
		Implementation of CAPs Based on a sample of four completed CAPs and one in-process CAP, four (80%) were implemented and four (80%) were implemented in a timely manner. It was not clear whether steps had been taken to implement CAP #5, since there were no status updates. Tracking CAP status There was a system for tracking the status of CAPs, using a tracking sheet that included the issue, action, anticipated outcome, responsible person, dissemination timeframe for completion, and a space for comments. The system needed to distinguish a CAP and its steps, allowing for one CAP to have a number of steps. One improvement to the tracking sheet would be the date the CAP was approved by the QA/QI Council. Another would be the addition of information in the comments column to explain delays, changes, etc. Of the 51 CAPs being tracked by the Facility, the tracking sheet indicated the status of 36 (71%) of the CAPs, and any action taken if a CAP had not been implemented. Management of CAPs The more recent QA/QI Council minutes (e.g., 1/24/13) included a section under Quality Assurance for follow-up on CAPs. In it, the QA Director reported on completed CAPs, including the date completed and the means of dissemination. The entries for that date included two CAPs recorded as completed for future dates (6/30/13 and 5/15/13). If in fact they had been completed ahead of schedule, the actual date of completion should have been entered. It was not clear if all CAPs were being reviewed at each meeting or at least monthly. It might be clearer for the minutes to include the tracking sheet, with notations to explain lapsed dates, completed CAPs, and evidence relied on to establish the success or failure of the CAP. Although the QA Director was presenting updates on individual CAPs in the last quarter as evidenced by the entries in the minutes of 1/24/13, there should be a clearly articulated plan for tracking and informing the Council of progress. It was not clear how the QA Director was: ▪ Maintaining summary information/data regarding CAPs and their status (number of CAPs and number overdue); and ▪ Whether this information was presented to QA/QI Council at least quarterly. Performance on the above metrics was not at the 90% level. In addition, the process for tracking CAPs should be clearly articulated, and then followed and documented in the QA/QI minutes along with presentation of evidence or follow-up to assure the desired result has been obtained. As a result the Facility was not in substantial compliance with this provision.	

#	Provision	Protocol	Compliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	<u>Evaluate effectiveness of CAPs</u> CCSSLC was not in substantial compliance with this provision. The QA Director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. Once a system is developed, based on a review of a sample of CAPs, the following metrics will be used to assess the Facility's compliance: ▪ For ___out of ___CAPs (%), documentation showed review of their effectiveness (i.e., outcomes), and for ___out of ___CAPs (%), documentation showed review of their timely completion. ▪ Of the ___ CAPs that appeared to need modification, ___ (%) were modified. ▪ Based on a sample of ___ completed CAPs and ___ in process CAPs, ___ (%) were discussed at QAQI Council. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show timely implementation. ▪ For ___ out of ___ (%) modified CAPs, evidence was present to show full implementation.	Noncompliance

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

1. The data list inventory should reference the QA monitoring tools for which data is maintained. (Section E.1)
2. The Facility should make improvements to the QA matrix as described with regard to Section E1. (Section E.1)
3. A Facility procedure should be developed to describe the data inventory, explain how reports are added or removed from the list and explain which data can be reported across the various areas, units, etc., and include that information on the data inventory. (Section E.1)
4. The QA plan narrative should be dated, and there should be evidence that it has been reviewed and revised if necessary at least once every 12 months. The QA plan should include the data inventory and the matrix as appendices. (Section E.1)
5. The QA plan narrative should include the items specified in the list above with regard to Section E.1. (Section E.1)
6. If the Facility has more than one tool for any sections of the matrix, they should be listed separately. (Section E.1)
7. Survey data (families, staff, individuals, etc.) should be listed on the data inventory. (Section E.1)
8. All monitoring tools listed on the matrix should be implemented as specified. If a tool is undergoing revision, the listed tool should continue to be used until the revision has been adopted. (Section E.1)
9. The Facility should address any recommendations/issues identified in other section reports related to the quality monitoring tools for those sections. (Section E.1)
10. When meetings are held between staff of the QA Department and section leads and/or their staff, minutes of the meetings should be maintained. (Section E.2)
11. The Facility should prepare a quality assurance report that can be distributed campus-wide. (Section E.2)
12. In the Facility's list of CAPs, each CAP should have a clear connection to data and should address either systemic issues identified in the data or issues with individuals that emerged from the data. (Section E.2)
13. If a CAP has several steps to address a single issue, the CAP should be listed as one cap with steps enumerated. (Section E.2)

14. CAPs should be numbered or otherwise identified to make tracking efficient. (Sections E.2 and E.3)
15. The Facility should describe a clear process for dissemination, and the tracking sheet should indicate the how, when, by whom, and to whom for each CAP. (Section E.3)
16. The tracking sheet should include the date the CAP was approved by the QA/QI Council. (Section E.4)
17. Information should be included in the comments column to explain progress, delays, changes, etc. (Section E.4)
18. The Facility should use a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. (Section E.5)

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 Self-Assessment for Section F, updated 3/18/13; o Action Plan for Section F, revised 3/18/13; o CCSSLC Provision Action Information for Section F, undated; o Draft Individual Support Plan (ISP), related assessments, Physical and Nutritional Management Plan (PNMP), Preferences and Strengths Inventory (PSI), ISP Preparation Meeting documentation, Community Living Options Information Process (CLOIP) worksheet, and Integrated Risk Rating Form (IRRF) for Individual #184; o Draft ISP Preparation Meeting document, IRRF, and Integrated Healthcare Plans (IHCPs) for Individual #156; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11; o In response to a request for a list of Qualified Developmental Disability Professionals (QDDPs) who have been deemed competent in meeting facilitation, the following statement: "None of the QDDPs have been deemed competent during this last reporting period;" o CCSSLC QDDP Listing with current caseload totals, undated; o Corpus Christi State Supported Living Center Individual Support Plan Meeting/Documentation Monitoring Checklist, revised 8/21/12 and 11/15/12; o Compliance and Inter-Rater Reliability Scores – Section F summary report and data, for September 2012 to November 2012; o Compliance and Inter-Rater Reliability data for January through March 2013; o Corrective Action Plan Re: Meeting with Respiratory, dated 7/16/12; o Corrective Action Plan Re: Zoning/Active Treatment Schedule, undated and updated 1/17/13; o Zoning/Active Treatment Meeting Minutes, dated 11/8/12; o Monthly Benchmark Report for Section S, dated 11/9/12, 12/10/12, and 1/14/13; o Corrective Action Plan Re: Meeting about Community Integration Specialists, dated 1/31/13; o Corrective Action Plan Re: Poor Quality Monthly Reviews, undated; o CCSSLC Integrated Protections, Services, Treatments and Supports policies revised since last review, including: ▪ CCSSLC Statewide Policy and Procedures, Policy #004.1, effective 11/20/12; ▪ Integrated Protections, Services, Treatments, and Supports – Table of Contents; ▪ F.1 – State Center Expectations for the ISP Process, revised 7/18/12; ▪ F.2 – The Initial Individual Support Plan (ISP) Process, revised 7/18/12; ▪ F.3 – Preferences and Strengths Inventory, revised 7/18/12;

	▪ F.5 – ISP Preparation Meeting, revised 10/2/12; ▪ F.6 – Submitting Assessments, revised 7/18/12; ▪ F.7 – Action Plans, revised 7/18/12; ▪ F.8 – Rights/Consent/Guardianship, revised 7/18/12; ▪ F.9 – Living Options Discussion, revised 7/18/12; ▪ F.10 – ISP Monitoring/Monthly Review Process, revised 2/19/13; ▪ F.11 – ISP Addendum Meetings, revised 2/19/13; ▪ F.12 – Staff Training, revised 7/18/12; and ▪ F.13 – Quality Assurance, revised 7/18/12; o CCSSLC Habilitation, Training, Education and Skill Acquisition, including: ▪ S.2 - Skill Acquisition Plans, implementation 1/17/13; and ▪ S.5 – Engagement; o Last 10 monitoring tools completed by the QDDP Coordinator, various dates; o Last 10 monitoring tools completed by the Quality Assurance Department Staff, various dates; o Supporting Visions: Person-Centered Planning, dated September 2012; o Admissions and Placement Department New Employee Orientation agenda, handout, and test, undated; o For the last year, aggregate data summary reports on: ▪ Assessments completed for ISPs, including timeliness; and ▪ Team member participation in annual ISP meetings; o A list of individuals admitted to the Facility since the last review, including the date of their admission and the date of their initial ISP meeting; o For the last year, total number of ISPs completed, total held over 365 days from previous meeting, and number filed more than 30 days from the meeting, from 2/1/12 through 1/31/13; o Five most recent monthly QDDP Summaries in which graphs were included, including those for: Individual #359, Individual #255, Individual #109, Individual #332, and Individual #369; o Five samples of training conducted for direct support professionals on ISPs, including for Individual #191, Individual #5, Individual #147, Individual #106, and Individual #110; o QDDP Discharge Summaries for: Individual #213, Individual #63, Individual #341, Individual #140, and Individual #231; o List of individuals with most recent ISP date, previous date, and date of filing, undated; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda, (ISPAs), Integrated Risk Rating forms, Integrated Healthcare Plans, Preferences and Strengths Inventory, Rights Assessments, Community Living Options Information Process worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly reviews, last two quarterly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation, for the following: Individual #58, Individual #311, Individual #279, Individual #301, Individual #59, Individual #298, Individual #111, Individual #359, Individual #252, Individual #38,

	Individual #141, Individual #79, Individual #310, and Individual #179; and o For individuals in the sample, the spreadsheets showing: a) attendance at the ISP meeting; and b) assessment submission. ▪ **Interviews with**: o Rachel Martinez, QDDP Coordinator; o Kimberly Benedict-Rodriguez, Director of Education and Training; and o Araceli Matehuala, Program Compliance Monitor. ▪ **Observations of**: o ISP meetings for Individual #184, Individual #91, Individual #268, and Individual #324; and o ISP Preparation Meeting for Individual #156.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section F, in conducting its self-assessment: ▪ The Facility was using a monitoring/auditing tool. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: o CCSSLC was conducting reviews/audits of ISPs using the Individual Support Plan Meeting/Documentation Monitoring Checklist. The Facility had continued to update this form. Revisions were made in June 2012, and again in November 2012. The Facility had been using some version of this form since July 2012. The audit tool focused on pre-meeting activities, the ISP meeting, and the ISP document. o Based on a review of the audit tool, it included many important questions/probes that should be helpful in identifying areas of best practice, as well as areas requiring improvement. As noted in the last report, the only caution would be that those implementing the form consistently look for quality. This will be important for some of the questions that are worded: "Did the team… (e.g., discuss action plans or integrated health plans, or review and approve the psychiatric treatment plan)." It would be possible to answer these questions "yes" or "no" without evaluating the quality of the discussion or reviews, which would result in limited valuable information. Moreover, in reviewing the Facility's Self-Assessment, it was not always clear that quality had been considered. It would be helpful to define the standards being used for many of the indicators in the tool. Based on interview with staff, the QDDP and QA Departments were working together to define methodologies. This should include the development of relevant standards. o The Self-Assessment identified the sample(s) sizes. Generally, this included the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The following staff/positions were responsible for completing the audit tools: a Program Compliance Monitor from the QA Department, and the QDDP Coordinator. However,

	based on interview, only the QDDP Coordinator's data was included in the Facility Self-Assessment. Particularly once inter-rater reliability is established, consideration should be given to including data from both. o The staff responsible for conducting the audits/monitoring had not been formally deemed competent in the use of the tools. Although the staff responsible had experience with developing and implementing ISPs, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o As the Facility recognized, adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. However, as discussed in more detail with regard to Section F.2.g, they were working on establishing it. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures. For example, the Facility maintained a database to track the timeliness of assessments, as well as attendance at ISP meetings. The QDDP Coordinator tracked the QDDPs that had been deemed competent in facilitation. Some of this information was included in the Self-Assessment. ▪ The Facility presented some of the data in the Self-Assessment in a meaningful/useful way, but improvements were needed in some areas. Specifically, on a positive note, the Facility's Self Assessment for Section F: o Consistently presented findings based on specific, measurable indicators. Areas requiring improvement included: o Did not include indicators that consistently measured the quality as well as presence of items. It was not consistently clear whether or not the quality of the ISPs was being assessed. For example, it was unclear if issues related to the quality of assessments, the comprehensiveness of action plans, or the quality of team's discussion and recommendations related to community living options had been assessed. o Did not distinguish data collected by the QA Department versus the program/discipline. As noted above, based on interview, the QDDP Coordinator's data was used for the Self-Assessment, and the QA data was excluded. No explanation of this was provided in the Self-Assessment. ▪ The Facility rated itself as being in compliance with none of the subsections of Section F. This was consistent with the Monitoring Team's findings. ▪ In many cases, the Facility data's identified areas in need of improvement. On a positive noted, the Facility's Self-Assessment for Section F consistently referenced the action plans, including specific steps within action plans that the Facility was implementing to address issues identified. This should assist in "closing the loop" to show that data that identify problems are acted upon.
	Summary of Monitor's Assessment: After participating in training from DADS State Office in October 2012 and January 2013, CCSSLC teams began using the ISP Preparation Meeting format, revised ISP template, revised Integrated Risk Rating form, and Integrated Health Care Plan format. At the time of the Monitoring Team's review, the Facility was still in the initial phases of implementing some of these forms and processes, and CCSSLC had not had the benefit of the more extensive training that two Facilities currently were undergoing. However, some improvements were noted, and Facility staff were able to identify some of the other areas in which deficits existed.

	Timeliness as well as quality of assessments, and team attendance at ISP meetings continued to be areas on which the Facility was working to make improvements. The QA/QI Council was regularly reviewing timeliness and attendance data. Some discipline heads were reviewing some assessments for quality. However, this was in the initial stages of development and implementation. As has been discussed in previous reports, comprehensive, thorough, and adequate assessments are the cornerstone of ISPs that adequately address individuals' strengths, preferences, and needs. With regard to individuals' ISPs, although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals' needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. The Facility recently had begun to use the Integrated Health Care format, which expanded the array of protections, supports, and services teams were discussing. However, teams were still not identifying the full configuration of supports and services necessary to address individuals' needs and preferences. Although action plans included more measurable action steps, ISPs generally continued to lack measurable objectives necessary to determine whether or not the supports and strategies were having the desired outcome (e.g., were they effective in improving the individual's health, or maintaining his/her current status). The Facility had adopted a new monthly report format. It was positive that the newest format included graphs to provide more information about individuals' ongoing process with skill acquisition programs. However, because the ISP action plans did not include many of the healthcare and other clinical supports the individual was provided, the monthly reports focused mainly on skill acquisition programs, and did not provide information about individuals' progress or lack thereof on issues related to behavior, psychiatry, healthcare issues, and/or habilitation therapy. The Facility had made progress with regard to its quality assurance system related to the ISP process. The QA Department and the QDDP Coordinator had continued to work together to revise the tool they used to monitor ISP meetings, as well as ISP documents. They were working on establishing inter-rater reliability, including modification of review tools and the related instructions. Efforts were in the initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development. The QA/QI Council was regularly reviewing some components of the data.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of	Since the Monitoring Team's last review, DADS had issued Policy #004.1: Individual Support Plan Process, dated 11/20/12. As appropriate, comments on the policy are	

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	the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	provided below in relevant subsections. The Monitoring Team's previous reports had identified the need for CCSSLC to tailor its policies to not only meet the requirements of the State policy, but also to describe in further detail some of the procedures or expectations that were specific to the Facility. Since the last review, the Facility had issued some revised policies. These also are commented on as appropriate in relevant subsections. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly, and the last two quarterly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. A sample was requested of the most recently developed ISPs from each residence on campus. Therefore, a variety of QDDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. This sample included plans for: Individual #58, Individual #311, Individual #279, Individual #301, Individual #59, Individual #298, Individual #111, Individual #359, Individual #252, Individual #38, Individual #141, Individual #79, Individual #310, and Individual #179. This was a limited sample due to the fact that State Office had identified two Facilities at which concentrated efforts were being made to improve the ISP process. Although CCSSLC had undergone some training on the new IRRF and IHCP processes, teams at the Facility had only begun using them fully at the end of January 2013, and teams had not had the full benefit of the more intensive training that was currently being offered to a couple of other Facilities. It was anticipated, therefore, that additional changes would occur to the ISPs at CCSSLC with both experience with the new process and additional training and technical assistance.	
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.	Progress had been made and/or sustained with regard to the facilitation of ISPs by one person from the team who ensures that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included: ▪ Policy #004.1 in Section II.F.1.b indicated that the QDDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. The Facility's Policy F.4: Individual Support Planning, implemented 10/12/12, further defined the role of the QDDP, including activities before, during, and after the ISP meeting. This policy defined the QDDP's role in notifying team members required to attend the meeting of the date and time, as	Noncompliance

#	Provision	Assessment of Status	Compliance
		well as the QDDP and Lead QDDP's responsibility for ensuring that necessary assessments were submitted, and if assessments were missing, taking action to obtain them. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QDDP was the team leader and responsible for ensuring team participation. ▪ An important role of the QDDPs was assisting individuals and their guardians to participate in the meetings. During the onsite review, in the meeting for Individual #184, the QDDP sought the participation of the individual, and facilitated the guardian's participation as well by trying to make sure that questions and comments the guardian raised were addressed. ▪ With regard to staffing, the Facility had a QDDP Coordinator and two Lead QDDPs, as well as a QDDP Educator. A total of 14 QDDP positions resulted in a QDDPs being assigned an average caseload of 18 individuals, with a range of 11 to 22. One of the challenges continued to be the turnover in QDDP positions. Often, QDDPs were promoted within CCSSLC. Although this was positive for other departments, it resulted in constant retraining of QDDPs. This likely impacted the speed with which the necessary changes could be made in the ISP process. ▪ In October 2012, State Office staff/consultants provided two teams at CCSSLC additional training on the completion of the IRRF. One of the State Office consultants also observed a number of ISP meetings, and provided technical assistance to the teams. In addition, in January 2013, a number of team members had attended scan call training on the At-Risk process. In mid-January, all teams began using the revised At-Risk process. However, as noted above, the more intensive training on the revised process was anticipated in the future. ▪ As is discussed in further detail with regard to Section F.2.e, the Q Construction: Facilitating for Success training was still provided to new QDDPs, and it included a competency-based component. In addition, the CCSSLC Individual Support Plan Meeting/Documentation Monitoring Checklist also assessed some of the competencies that QDDPs needed to demonstrate. At the time of the most recent review, none of the QDDPs had been deemed competent in meeting facilitation or the development of ISPs. ▪ During the week of the review, the Monitoring Team observed four team meetings, including those for Individual #184, Individual #91, Individual #268, and Individual #324. Progress had continued to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had continued or begun included: o At annual ISP meetings ground rules were clearly set forth, and the ISP format in the revised policy provided an agenda.	

#	Provision	Assessment of Status	Compliance
		o Paper hung on the walls or white boards were used to track key components of the ISP process, such as the individuals' preferences, and action plans that needed to be developed. In addition, a note-taker was present to allow the QDDP to run the meeting without needing to maintain detailed notes. o The teams had a more comprehensive discussion than in the past about a wider variety of the protections, supports, and services. This included review of plans, such as the PNMP, with team discussion and modifications made, as necessary. o The team for Individual #184 also made good efforts to include some of the individual's preferences and strengths into plans designed to address some of his need areas. For example, Individual #184 had a program to walk four times a week, but he frequently refused. The team tried to develop some person-centered approaches such as moving the implementation of the program that better fit his preferences, and building in tangible incentives. Similarly, Individual #184's team discussed person-centered ideas about ways to have him comply with wearing his helmet to reduce his risks for injuries related to falls. o Based on observations on site, as well as review of ISP documents, QDDPs and teams were using some of the necessary data to make decisions in relation to individuals' risk areas, but some important data continued to be missing from these discussions. A number of gaps also continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. o Teams were observed discussing action plans in some detail, including due dates for specific action steps. However, as discussed below, draft action plans were not available, and teams did not discuss and approve measurable objectives or clinical indicators. Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was continuing to improve, but for none of the plans reviewed (0%) or meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, none of the 14 QDDPs had yet been deemed competent with meeting facilitation. ▪ Based on limited observations of meetings held the week of the onsite review, areas in which QDDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to:	

#	Provision	Assessment of Status	Compliance
		o Continuing to expand the depth of the preferences identified for individuals. QDDPs should continue to challenge teams to define what it is the individual prefers about items such as foods or activities to allow teams to offer the individual new experiences, and to expand the discussion to include preferences related to work, relationships, past experiences, future opportunities, etc. These then should be incorporated into action plans. o Continuing to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain. o Although some improvements were seen, seeking data from various team members to assist in decision-making, and justify the teams' conclusions. For example, data should be used consistently, including when reviewing PBSPs and skill acquisition programs, as well as outcomes related to individuals' risks. In addition, as appropriate, historical information or causation should be investigated fully (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. o Increasing teams' discussion of action plans. For example, although health care plans for individuals were referenced as well as PBSPs, and psychiatric treatment plans, drafts were not presented, reviewed and modified by the team, and/or approved. o Setting forth clearly the methodologies or how outcomes will be accomplished. o Focusing teams on defining measurable, functional objectives during team meetings. o Assisting teams to articulate meaningful outcomes for individuals. ▪ Most of the ISP meetings the Monitoring Team observed were lengthy. In addition, the majority of the time was spent on the risk rating process. Although this was an essential activity in which teams needed to engage, it resulted in limited time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics. Focus should be placed on the preparation before the meetings, so that meeting time is available for both the clinical discussions that need to occur, but also adequate time is devoted to developing supports to assist individuals to expand their independence, involvement in the community, and in leading meaningful lives. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. If action plans	

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		were presented in draft format, including Integrated Health Care Plans, team members could review them prior to the meeting, and discuss necessary changes and additions at the meeting. As during past reviews, during the Monitoring Team's discussions with the QDDP Coordinator, she correctly identified areas in which additional work was needed. For example, there was good consistency between her assessment of the ISP meeting that she and the Monitor attended during the onsite review week. It was important that the Facility staff had this insight, and were working with State Office staff on some specific areas in which they knew improvements were needed, Progress had been made. However, continued work was needed to ensure the ISP process resulted 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 individual's preferences and needs.	In Section II.A, DADS Policy #004.1 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. Attendance requirements now were determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. CCSSLC Policy F.5 had been revised to include the State Office "Annual ISP Meeting IDT Attendance Indicators" designed to provide teams guidance on this process. Thirty days prior to the scheduled ISP meeting, CCSSLC Policy F.4 on Individual Support Planning required QDDPs to send an ISP Meeting Attendance Memo to notify the team members that they were required to attend the ISP meeting. Although the Facility maintained an ISP database that included information on attendance, the reports from this database were not easy to decipher according to staff. As a result, spreadsheets now were maintained in which attendance requirements were entered based on completed forms from the ISP Preparation Meetings, and attendance sign-in sheets from the ISP meetings. Based on data the Facility provided for ISPs held between October 2012 and January 2013, average attendance rates were between 59% and 64%. This data was broken down by discipline, and showed fairly consistent attendance by individuals, QDDPs, direct support professionals (DSPs), Registered Nurses (RNs), and Vocational Services. Other disciplines had issues with attendance.	Noncompliance

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		Based on discussion with the QDDP Coordinator, this data was presented to the QA/QI Council each week for the prior week. Efforts continued to improve attendance. Based on the sample of 14 ISPs the Monitoring Team reviewed: ▪ For 13 of 13 (100%), at the ISP Preparation Meeting, the team defined the members of the team that should attend the annual meeting. Those that did not included Individual #59, who was a new admission, and had not been at the Facility long enough to have an ISP Preparation Meeting. ▪ Eleven individuals had strengths, preferences, or needs that potentially required additional team member participation. For none of these 11 individuals (0%), the team had adequately justified why such team members' participation was not necessary. Those that did not have adequate justification included: Individual #111, Individual #301, Individual #279, Individual #311, Individual #58, Individual #310, Individual #359, Individual #79, Individual #38, Individual #141, and Individual #298. Of note, in identifying team members that needed to be present, the team often used the phrase "assessment is sufficient" as the justification for not having a team member attend the ISP meeting. This is not an adequate justification. The specific reasons that an assessment is sufficient need to be provided, or a further explanation of the individual's status or lack of needs in a specific area is necessary. ▪ For none of the 14 (0%), it appeared that a duly constituted team participated in the annual meetings. The Facility had made progress in beginning to use the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and had a working system to track and trend the resulting data. However, based on the Monitoring Team's review, the data was did not show when teams failed to identify an appropriate team member, and justifications on ISP Preparation Meeting documentation generally were not sufficient to explain why team members supporting the individuals did not need to be present. CCSSLC was beginning to identify issues with attendance of identified team members and attend to them during the QA/QI Council meetings, but Facility data showed significant issues with a number of disciplines' attendance at meetings. The Facility remained out of compliance with this provision.	
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.	DADS Policy #004.1 no longer defined "assessment" in a comprehensive fashion. The former draft had defined it as: "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the 'Action Plans' section of the ISP." The revised policy did not include a definitions section, and Section	Noncompliance

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		III.C focused on the assessments' role in focusing on the individuals' personal goals and appropriateness of transition to the community. Although these were two important roles of assessments, they were not the only ones. Progress had been made and/or sustained with regard to the conduct of assessments. Positive developments included: ▪ The State Office had developed an Assessment/Report Schedule – Minimum Requirements, dated 10/15/12, which was an attachment to the revised policy. Although it will be important to ensure that this document addresses the Settlement Agreement as well as regulatory requirements, it appeared to provide a good framework from which teams could work to determine the standard assessments that should be completed, and the timeframes for their completion. ▪ The Facility had developed a Facility-specific policy, Policy F.6 – Submitting Assessments. It included procedures for saving completed assessments on the shared drive, and completion of the IRRF. ▪ As noted above, in reviewing a sample of ISPs, individuals' teams had begun to identify necessary assessment at the ISP Preparation Meetings. As noted below, problems were identified with this process, including a lack of justification for assessments related to individuals' specific needs. Areas of concern included: ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for ISPs meetings held between 4/10/12 and 1/31/13, significant issues were noted with regard to the timeliness of assessments. For example, for the month of January 2013, specific disciplines' performance ranged for zero to 100 percent compliance, with an average for all disciplines of 78 percent. This was an improvement from December 2012, when the range was eight to 94 percent, with an average for all disciplines of 61 percent. The QA/QI Council was reviewing this data regularly, and efforts were being made to improve timeliness. ▪ The Facility as well as State Office recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. 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 detail throughout this report with regard to the sections of the Settlement Agreement that address nursing services (Section M), physical and nutritional supports (Sections O), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychology, psychiatry, OT/PT, and speech and language assessments. Reportedly, the State Office was developing a list of	

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		quality indicators for each of the discipline-specific assessments. In order for adequate protections, supports and services to be included in individuals' ISPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. ▪ As discussed in previous reports, assessments also frequently did not include adequate recommendations. Some of the issues noted included no or limited specific recommendations, or an incomplete list of recommendations; and recommendations not oriented to the development of action plans. Based on the sample of seven ISPs: ▪ One individual was newly admitted, and had not had an ISP Preparation meeting. For the remaining 13, at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting for 13 (100%). ▪ In reviewing the ISPs for fourteen individuals, the teams for four individuals (29%) had identified the comprehensive assessments necessary to identify the individuals' strengths, preferences, and needs, and/or had provided adequate justification for not requiring such assessments. This included Individual #279, Individual #252, Individual # 359, and Individual #301. For the remaining individuals, they had needs for which assessments were not requested, and the teams did not provide adequate justification for not requesting assessments. ▪ For none of the 14 (0%), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting. In the past, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, this often appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring 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 ISP. Most often, the teams did not adequately analyze the information and/or identify areas in which changes might be made to attempt to reduce the frequency of such occurrences. Although some improvements were seen with the quality of some assessments, and some infrastructure and guidance had been developed regarding the frequency and/or indications for completion of assessments, concerted efforts of all team members will be necessary to bring the Facility into substantial compliance with this provision.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines	As indicated in previous reports, although the new ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of	Noncompliance

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	the protections, services, and supports to be provided to the individual.	assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In one of the 14 plans (7%) were all recommendations resulting from assessments addressed in the ISPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. That one plan was for Individual # 359. ▪ As noted above, although some improvements were seen, the quality of assessments was lacking. Of particular concern were the issues related to the recommendations included in assessments. There was a need for assessments to summarize in the recommendations the detailed protections, services, and supports that needed to continue for the individual, as well as changes to support either assessment findings or the need to improve the configuration of services the individual required. To the extent possible, these recommendations should be written in specific, observable, measurable terms to facilitate their inclusion in action plans. Efforts were needed to improve the recommendations included in assessments, as well as to ensure that teams considered, and either incorporated recommendations or provided justification for not incorporating them. The Facility remained out of compliance with this provision.	
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).	Based on information the Facility provided, the following activities had occurred to provide additional education to QDDPs regarding community living options: ▪ On 9/13/12, the QDDPs, along with other IDT members, were trained on the Home and Community-Based (HCS) Waiver program. One of the Local Authorities provided the training. ▪ On 1/9/13, QDDPs also participated in training on the Community Living Options Information Process. ▪ On 3/5/13, QDDPs attended the training on Community Transition Process. ▪ As discussed with regard to Section T, New Employee Orientation now included a session on most integrated setting practices. 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. A subset of seven plans were reviewed including those for: Individual #58, Individual #311, Individual #279, Individual #301, Individual #59, Individual #298, and Individual #111. The following highlights some of the findings: ▪ In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation about the individual's appropriateness for a more integrated/less restrictive setting. In addition, at the	Noncompliance

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		ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the seven ISPs reviewed, for four (57%), all of the assessments included the applicable statement/recommendation. All assessments for Individual #301, Individual #279, Individual #311, and Individual #58 included a recommendation. For Individual #59 and Individual #111, only the Functional Skills Assessment did not include a recommendation. o Of the seven ISPs reviewed, one of the individuals had been referred for transition to the community. For the remaining six individuals, six individuals' ISPs (100%) included a recommendation from the professionals on the team to the individual and LAR. However, for only one of these individuals (14%) was adequate justification provided (i.e., Individual #279, whose team recommended transition, but the guardian chose not to pursue transition). The following provide examples of inadequate justification for teams' conclusions: ▪ Based on the ISP for Individual #58, the PCP, SLP, and Nurse recommended against community living. From the ISP, it was unclear what the other team members recommended. In the section of the ISP in which the overall team recommendation independent from the individual and guardian was documented, these three team members were again cited as making the determination that Individual #58 "would not benefit from moving to a less restrictive environment at this time." No reason or justification was provided, and it remained unclear what the rest of the team recommended. This was concerning given that in their assessments other team members (e.g., Psychology, OT/PT, dental, vocational, and the FSA) had indicated he could be supported in a less restrictive setting, but no mention of this was made in the ISP. The ISP also appeared to be inaccurate, because in the SLP's assessment as well as the nursing assessment, the assertion was made that he could be supported in a less restrictive environment. The PCP appeared to have a concern about a particular health issue that was currently under review, but this was not further delineated in the ISP. However, the audiologist indicated that his behaviors "mitigate against community placement." ▪ The ISP document for Individual #311 indicated that except for OT/PT, all team members' assessments indicated he could be served in a less restrictive setting. However, during the team	

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		discussion: "the team noted that while he may be able to be served in a less restrictive setting, [Individual #311] does not respond well to change and has a history of failing health when his environment changes. The team agreed it could be detrimental to [Individual's] physical and emotional health initiate [sic] a change from his current living environment. The team agrees it would be beneficial for [Individual] to remain at CCSSLC." The team did not reconcile the recommendations in the assessments with this conclusion, and provided no justification for its joint recommendation (i.e., a description of the history related to changes in environment and failing health), nor did the team appear to consider the possibility of a slow transition process. ▪ Individual #301 did not have a guardian, and was unable to communicate his decisions. His team recommended that he not be referred for transition to the community with the following justification: "...as noted by [Individual's] medical team, he has serious respiratory problems and his seizures have intensified recently. These medical concerns at present mean he needs time to stabilize medically before a referral to the community can be reconsidered." However, all assessments had statements indicating that assessors believed he could be supported in a less restrictive environment. No explanation was provided regarding how all the team members changed their minds during the ISP meeting. ▪ The team indicated in the ISP that the "facility discipline members (independent of the resident and LAR/family) determined that [Individual #298] would not benefit from moving to a less restrictive setting." However, the reason they provided was that it was her request to remain at CCSSLC, and her father/guardian would like her to remain there. As a result, this was not an independent recommendation, but a recommendation based on the individual and guardian's wishes. Moreover, it was not consistent with the statements in the team's assessments, and no justification was provided for team members' changes in opinion about her appropriateness for a more integrated setting. Most assessments included a statement about her appropriateness for a more integrated setting, except for the psychiatric and vocational assessments. Most said that she could be supported in a less restrictive	

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		setting. The exceptions were audiology in which the assessor indicated that there were no audiological contraindications, but "there may be sufficient other reasons due to the complexity of this resident's care that community placement is not desirable." However, no specific reasons or complexities were delineated. The FSA indicated no barriers existed, but the guardian wanted her to remain at CCSSLC. Again, this did not represent an independent recommendation. ▪ For Individual #111, the majority of assessments indicated he could be supported in a less restrictive setting, except for the psychology, medical, and psychiatric assessments. The psychological and psychiatric assessments were both approximately a year old. All three of these assessments referenced his recent admission and/or failed community placement due to his behavioral issues as the reasons. The team made an independent recommendation, but it was not adequately justified. Specifically, the team indicated that he continued to require more structured programming. However, no justification was provided such as data related to his behaviors, or any indication of why the team believed such structure could not be provided in a community setting. In addition, the ISP provided no reconciliation regarding the many assessments that indicated he could be supported in a less restrictive setting with those that did not. ▪ 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 obstacles. In summary, teams were identifying obstacles, but the lists were not consistently complete, including the identification of the specific reasons for LAR's choice not to pursue transition to the community. Action plans often were not developed, and when they were, they were not sufficiently individualized. ▪ QDDPs continued to develop Discharge Summaries for individuals that transitioned to the community. It was important to provide a document summarizing the individual's current progress on the ISP, as well as other key information. As the QDDP Coordinator indicated, the process was a work-in-progress, because as individuals' ISPs grew in content, for example, now including the IHCPs, the format and content of this document also required revision. Although team members generally were including statements in their assessments with	

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		regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations most often were not justified. When disagreements were noted amongst assessment recommendations, their resolution was not consistently explained. The identification of and plans to overcome obstacles to transition were not yet adequately addressed. The Facility remained out of compliance with this provision.	
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;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; and topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" CCSSLC Draft Policy F.7: Action Plans, dated 7/18/12, included some of the key points from the State Office policy. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the last report, teams were making efforts to identify individuals'	Noncompliance

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		preferences. As part of the new ISP process, the Facility had begun to utilize the Preferences and Strengths Inventory. Based on review of the sample of ISP: ▪ All 14 of the ISPs reviewed included a listing of individuals' preferences and strengths. As the Monitoring Team's previous reports have noted, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. ▪ None of the individuals' teams (0%) had effectively incorporated their preferences into related action plans. Of note, during an ISP meeting the Monitoring Team observed on site, the team for Individual #184 used his preferences to develop action plans, including plans to overcome barriers to service delivery. For example, Individual #184 had a program to walk four times a week, but he frequently refused. The team tried to develop some person-centered approaches such as moving the implementation of the program that better fit his preferences, and building in tangible incentives. Similarly, Individual #184's team discussed person-centered ideas about ways to have him comply with wearing his helmet to reduce his risks for injuries related to falls by using his preferences for specific types of hats. ▪ None of the individuals' teams (0%) had effectively incorporated their strengths into related action plans. Strengths were not regularly built upon to address other need areas. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> Based on a review of sample ISPs and ISP Preparation Meeting documentation: ▪ None of the plans reviewed (0%) included a list of priority needs. ▪ In none of the plans (0%) was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. Although the ISP Preparation Meeting documentation now included a list of goals the team had decided upon, no explanation was provided of how the team made these decisions. For example, no rationale was provided regarding why one of the individual's specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. ▪ In none of the 14 ISPs reviewed (0%) were barriers identified and addressed. Although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams sometimes cited individuals' behaviors or attitudes as preventing them from participating in activities (e.g., work), but teams had not clearly defined such issues as barriers,	

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		and/or implemented plans to address them. On a positive note, as noted above, during the ISP meeting the Monitoring Team observed for Individual #184, his team identified barriers to his wearing his helmet and attending PT sessions, and developed plans to overcome them. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ Thirteen of the 13 ISPs (100%) reviewed included specific skill acquisition action plans for implementation in the community. Individual #179 did not, but his fragile medical condition (i.e., constant use of oxygen, frequent suctioning and limited time in his wheelchair) appeared to limit trips into the community. This was an area in which the Facility had continuously improved. ▪ One of the 13 individuals' ISPs (8%) included at least one measurable objective to enhance individuals' participation and integration into their communities. Individual # 359 had two community skill acquisition programs: one to improve his dining skills in a sit-down restaurant and one to teach purchasing skills in a store. Both included steps with measurable components. Although progress was noted, the following problems continued to exist: ▪ The skill acquisition programs generally involved implementation once a week or once a month (e.g. Individual #311, Individual #279, and Individual #301). An exception was Individual #59. He had a community participation goal for being in the community four times a week for 50 weeks out of the year. He had community SAPs for requesting applications for jobs and using community resources such as the barbershop. ▪ Most of the community-related objectives were not written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. Although CCSSLC had made some progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs or ISP Preparation Meeting documentation reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. All of the ISPs reviewed had action plans that addressed community skill acquisition, but they generally did not encourage participation in the community with nondisabled peers.	
	2. Specifies individualized,	The action plan section of the ISP was where measurable goals/objectives, the	Noncompliance

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	observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	treatments or strategies to be employed, and the necessary supports were to be detailed to attain identified outcomes related to each preference, meet needs, and overcome identified barriers to living in the most integrated setting appropriate to the individual's needs. The Facility recognized that this was an area in which additional training and technical assistance was needed. In February 2013, the QDDP Coordinator provided training to the QDDPs on action plan development. The training materials included some sample action plans. Although these samples provided a number of action steps that were measurable or observable, some of them were not (e.g., "PNMP: Direct Care Staff will monitor and assist Jack in the use of the motorized wheelchair," and "Jack will be provided effective physical activity and diet as evidenced by continued weight loss"). The training was followed by a written test. Although the test was not competency-based (i.e., did not require participants to write action plans that met the standards), it did provide a sense of the knowledge QDDPs had with regard to action plans. The following summarizes the findings related to action plans: ▪ None of the fourteen plans reviewed (0%) included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. ▪ None of the plans (0%) included a full set of measurable objectives. ▪ This negatively impacted the intensity of individuals' active treatment and habilitation, the supports they were provided, and the teams' ability to measure progress, or lack thereof. ▪ 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. This also requires the development of action plans in ISPs. In summary, action plans often were not developed, and when they were, they were not sufficiently individualized. The following summarizes concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Since the last review, at CCSSLC, the scope of these goals and objectives had continued to increase. This was a positive development. Action plans in ISPs continued to include skill acquisition plans. However, the Facility had not yet included the Integrated Health Care Plans as part of the ISP. It remained a separate document that the team discussed, but the plans developed were not part of the ISP action plans. At times, PBSP objectives were included, but often only a reference was made to implementation of the PBSP. Similarly, psychiatric plans were noted as having been "approved" in the ISP narrative, but they were not incorporated into the ISP through the inclusion of measurable	

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		goals or objectives. ▪ Many goals and action steps were not measurable, and at times, included more than one item to be measured. Examples included: "level of supervision at [Individual's] request," "Admission behavior support plan in place," "In the course of his work toward his GED, [Individual] will learn to read to increase his general skills at living in the community," "[Individual] will have training in place to help her become more independent," "[Individual] will have training in place that will help her reduce the need for restrictions," "continue PBSP," or "Continue psychiatric services." ▪ As is discussed in further detail with regard to Section I, the action plans teams had developed for individuals' at-risk issues did not adequately address their needs, and did not include measurable objectives necessary to determine: a) if the supports outlined were provided as required; or b) whether or not the supports and strategies were having the desired outcome (i.e., were they effective in improving the individual's health, or maintaining his/her current status). ▪ Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. Although some money management programs were included, most restrictions had no associated plan identified. ▪ More frequently, action plans referenced the implementation of physical and nutritional support plans (PNMPs). However, therapy plans, including walking programs, use of adaptive equipment, as well as integration of alternative or augmentative communication (AAC) devices were infrequently in the plans reviewed. Moreover, functional, measurable objectives and/or skill acquisition goals related to therapeutic interventions infrequently were included in ISPs. Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant work was needed. The Facility remained out of compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Based on observations of meetings and team discussions, and review of ISPs, the following comments are made with regard to the comprehensiveness of ISPs: ▪ Integration of various plans (e.g., PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, etc.) in a measurable way into the ISPs, through, for example, measurable objectives was generally not seen. Although the PNMPs were frequently identified in action plans and the team "approved" other plans, such as the PBSPs and psychiatric treatment plans, no reference was made to the specific plan approved (i.e., by date), and limited, if any, goals/objectives/action	Noncompliance

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		steps were included in the ISPs in relation to plans other than PNMPs. ▪ Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) was seen more frequently than during past reviews. However, the focus tended to be on implementation, and other areas often were missing or not well defined. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. ▪ The IHCPs did not consistently include the supports that the team identified in the IRRF. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ Most plans included reference to skill acquisition plans, as well as service objectives. Skill acquisition plans were generally included as overall topic areas that the SAPs would cover. It was unclear whether once approved, the teams approved the SAPs, and they were incorporated into the ISP through an ISPA. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. Previous reports have provided details about what was missing. None of the 14 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, including the IHCPs, this was in its initial stages of implementation. Some limited improvements were seen. However, as noted above, teams will need additional coaching and mentoring to fully implement the process and develop ISPs that meet this requirement of the Settlement Agreement.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The following findings are based on reviews of the sample of ISPs. ▪ For none of the 14 ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the 14 ISPs (0%), the roles of the persons identified as responsible were clearly defined. The following summarizes some of the problems noted: ▪ Often two positions were identified as responsible for the completion of action steps, but it was not clear who was responsible for what. As one example, when direct support professionals and Habilitation Therapy were responsible for "Reminders to slow rate of eating and take small bites per her PNMP," it was difficult to determine for what staff were responsible, or what the associated	Noncompliance

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		timeframes meant. ▪ An issue related to the identification of staff responsible noted continued to be the use of the term "IDT" as opposed to a specific member(s) of the IDT. Particularly, when it comes to monthly monitoring of programs/supports, it will be important for one person to be identified. In addition, by using this broad description everyone was responsible, but no one was responsible, reducing the level of accountability. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. It will be important, though, as discussed elsewhere to ensure that their roles are clearly defined, as well as the methodologies they should use to implement action steps. With regard to methodologies in action plans: ▪ In none of the 14 plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although more of the methodology was included than seen during past reviews, steps were often missing. For example, overall action steps such as "[Individual] will obtain his GED" required specific delineation of the steps that would be taken, by whom, and in what time frame. ▪ As noted above, sometimes methodology was included in the IRRFs for addressing at-risk issues, but the ISPs did not include action plans with the necessary detail. ▪ In addition, as is discussed with regard to Section I, action plans for individuals, identified as being at risk, frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The IHCPs set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and specific team members should be identified as responsible for the various steps required to complete the action plans.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for	Most plans included some practical and functional interventions (e.g., Individual #111, Individual #298, Individual #59, Individual #279, Individual #311, and Individual #58). Some of the teams had clearly tried to identify interventions to expand individuals' independence in a functional manner. Some examples included training on the use of the	Noncompliance

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	services and supports and are practical and functional at the Facility and in community settings; and	bus, cleaning personal items (e.g., lapboard and helmet), using a towel for privacy, learning to dial a phone number, making a recipe, etc. However, none of the 14 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. Such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals at-risk, psychiatric treatment plans, nursing care plans, OT/PT treatment plans, and PBSPs. In addition, as noted in previous reports, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility, was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. One of the 14 plans reviewed included a goal related to cooking. None of the plans reviewed included goals related to housekeeping or yard work, which would be typical activities for independent adults. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at CCSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community.	
	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	Based on the review of the sample of ISPs: ▪ None of the 14 ISPs reviewed appeared to be driven by a review of objective data for each of the related action plans, and the presence or lack of progress on measurable objectives and outcomes. Based on the Monitoring Team's observations of ISPs during the onsite review, particularly for clinical plans (i.e., IHCPs, PBSPs, counseling plans, therapy plans, etc.), teams did not discuss the data to be collected or reviewed or the frequency. Similarly, in reviewing ISPs, often the action steps in the IHCPs identified the frequency of data	Noncompliance

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	data collection, and the person(s) responsible for the data review.	collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. Generally, in the IHCPs reviewed, in the column for "Persons Responsible for Reviewing Progress and Effectiveness & Frequency of Review," the Persons Responsible were identified, but not the "Frequency of Review." The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., goals/objectives related to integrated health care plans, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Although teams discussed data in the context of the IRRF, the data available on the IRRFs varied in quality and comprehensiveness. This is discussed in further detail with regard to Section I. Of ongoing concern was the lack of data presented in the ISP and/or IRRF in relation to SAPs, behavioral health plans (i.e., PBSPs, psychiatric treatment plans, and counseling plans), as well as direct therapy plans. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet fully implemented to determine the reliability of the data, but efforts were beginning in this regard. However, there continued to be some indications that the data being collected was not reliable. Since the last review, improvement continued to be seen with regard to data being used to inform some of the at-risk discussions. However, data that should have been included, but was not, related to skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, psychiatric treatment plans, etc.), and details regarding individuals' successes or failures, etc. The Facility remained in noncompliance with this requirement.	
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 in the previous reports, and based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	Noncompliance
F2c	Commencing within six months of	DADS Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to	Noncompliance

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	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.	staff who must implement it. At the time of the review, the ISP 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. Copies of the ISPs as well as the skill acquisition programs also were accessible to staff in Individual Notebooks. The Lead QDDPs were responsible for checking four random Individual Notebooks each week to ensure the ISPs were present and up-to-date. Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. However, as more IHCPs are developed, it will be important to ensure that clinical terminology is included, but defined as appropriate. Another issue related to comprehensibility of the seven ISPs reviewed was the lack of delineation of responsibility for the implementation of the plan. Although as noted above, the role of direct support professionals was becoming better defined, this in large part was due to the fact that the ISPs 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., PBSPs, 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 ISP. 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. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports (e.g., "encourage" and other similar terms would be difficult to implement). The QDDP Coordinator recognized with the more extensive clinical information in the ISPs, likely it would be difficult for the DSPs to determine their specific responsibilities. Consideration was being given to the possibility of adding information to the Individual Profile Sheet. Although this was an idea worth pursuing, it will be important to ensure that information is not lost in translation. The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily understood terminology.	
F2d	Commencing within six months of	Monthly reviews were being completed more consistently than in past reviews. More	Noncompliance

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	the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	specifically: ▪ Based on the sample of 14 records, 11 (79%) had timely monthly reviews each month for the previous three months. Those that did not included Individual #311 (i.e., one month late by a month), Individual #79, and Individual #279. ▪ For none of the monthly reviews completed (0%), the responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions. The reports only included the QDDPs' review of skill acquisition programs, and some brief updates on specific topics (e.g., incidents and allegations, hospitalizations, peer-to-peer incidents, etc.). Although QDDPs were required to review the Integrated Progress Notes (IPNs), no summary was provided with regard to various team members' review of "each program or support included in the ISP." ▪ For two individuals (i.e., Individual #301 and Individual #311), a lack of expected progress was noted requiring action. In none of these instances (0%), adequate action was documented. In addition, as noted above, the reviews conducted did not comprehensively address all action plans included in individuals' ISPs. Therefore, it remained unclear if problems existed that should have been addressed. An ongoing concern about the monthly reviews was the lack of data to substantiate individuals' progress or lack thereof. Shortly before the Monitoring Team's review, CCSSLC had begun to use a format of the monthly review that included graphs illustrating the data. A sample of these reports were reviewed, including those completed in the month of March for Individual #332, Individual #109, Individual #255, Individual #359, and Individual #369. The graphs improved the information included in the reports. However, the narrative summaries should provide a description/analysis of the data, so it is clear to the reader what the data means. This is particularly important when ISPs do not include the specific SAP language, because without it, the data is fairly meaningless. As one of many examples, Individual #369 had the following action step in her ISP: "Implement SAMs SAP to help [Individual] learn to self-administer medication." Data was provided without any indication what the measurable objective was. As a result, the graph could not be interpreted. The summary for this action step did not assist the reader in understanding the data. Moreover, examples are provided in various sections of this report of individuals experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to medical and nursing care, as well as physical and nutritional management supports. Although some progress had been made in timely monthly reviews and integrating skill acquisition data into the QDDPs' monthly review, the Facility did not yet have an	

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		adequate monthly review process in place. The Facility remained out of compliance with this provision.	
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.	Previous reports have described training CCSSLC staff underwent with regard to the ISP process. Updates included: ▪ In September 2012, the Supporting Visions: Person-Centered Planning curriculum used at New Employee Orientation (NEO) was updated. At CCSSLC, the Competency and Training Department taught the course. However, it was anticipated that by the end of the year, the QDDP Educator would be involved in providing training at NEO. ▪ In October 2012, State Office staff/consultants provided two teams at CCSSLC additional training on the completion of the IRRF. One of the State Office consultants also observed a number of ISP meetings, and provided technical assistance to the teams. In addition, in January 2013, a number of team members had attended scan call training on the At-Risk process. In mid-January, all teams began using the revised At-Risk process. ▪ The QDDP Coordinator, the Director of Education and Training, two Program Coordinators, and a Program Compliance Monitor worked together to develop a draft I-Learn course entitled: "Individual Support Plan Cycle: What position do you play in the team?" It was awaiting production through the I-Learn process to make it available electronically. The target audience was all direct support professionals. The QDDP Coordinator reported that based on the QA/QI Council's review of it, thought was being given to trying it with a sample of staff to determine if the content was too advanced. It was premised on a football theme. Based on a review of the draft, it provided thorough review of the various components of the ISP cycle. It was heavy in content, though, and the QA/QI Council's recommendation to pilot it was a good one. Given that the audience was expected to be direct support professionals, consideration also should be given to further defining their specific roles in the various parts of the process, including examples of how their full participation is beneficial, and their lack of participation could have negative effects on the quality of the process. Although some information related to their specific roles was included, this could be enhanced. ▪ The QDDP Coordinator had developed a Job-Specific Training Schedule. It identified the QDDP responsibilities, as well as essential job functions, and set forth a structure for documenting that new QDDPs completed training on each of the listed items. Although it was not competency-based, the list of responsibilities and functions appeared thorough. It was positive that a more formal process for ensuring QDDPs were familiar with their many duties had been developed and was being implemented for new QDDPs. ▪ The Q Construction: Facilitating for Success training was still provided to new	Noncompliance

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		QDDPs. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. As indicated in previous reports, as the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. The CCSSLC Individual Support Plan Meeting/Documentation Monitoring Checklist also assessed some of the competencies that QDDPs needed to demonstrate. It did not identify specifically which indicators were related to a QDDP's competence versus other team members' competence. However, it provided a number of important measures related to facilitation, as well as completion of the ISP document. ▪ The QDDP Coordinator also continued to provide training to QDDPs as CCSSLC policies or procedures changed. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP document. Such competency measures should be clearly defined and include criteria for achieving competence. As noted above, work was underway to address the facilitation component of competency-based training, and the monitoring checklist included some indicators that could be used to assess QDDPs' facilitation skills as well as their skills in finalizing the ISP document. At the time of the last review, the QDDP Educator had achieved competence, but he had since moved to another position. At the time of the most recent review, none of the QDDPs had been deemed competent in meeting facilitation or the development of ISPs. ▪ Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. ▪ As recommended in the previous report, there should be additional training on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's strengths and preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on the individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. ▪ This section of the Settlement Agreement also requires: "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."	

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		The Facility provided samples of training documentation for five individuals' ISPs. Based on the documentation, it was difficult to determine how the training was presented, or what it included. In addition to a coversheet, the documentation included a sign-in sheet, and copies of the individuals' action plans. According to the coversheets, training for three of the five took a quarter of an hour, one took a half hour, and this section was left blank for one person. This was a short time in which to cover the implementation of the action plans, including the specific responsibilities of staff. No documentation was provided to substantiate that the training was competency-based. Although it was positive that action plans were being reviewed with staff, its adequacy could not be determined based on the documentation. Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts on providing additional training and technical assistance to improve the team process during team meetings, QDDPs' competence with meeting facilitation as well as the development of the ISP documents should be assessed, and the Facility should ensure that staff responsible for the implementation of the plans successfully complete competency-based training.	
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.	Based on summary data the Facility provided with regard to individuals' most recent and previous ISP dates, between 2/1/12 and 1/31/13, 247 ISP meetings had been held. Of the 259 meetings held, all (100%) were held within 365 days of the previous meeting. Based on information the Facility provided, two individuals that had been admitted to the Facility in November 2012 had initial ISPs completed within 30 days. The Facility tracked the dates that ISPs were completed and filed. Within this time period, of the 247 meetings held, 165 (67%) plans were completed and filed within 30 days of the ISP meeting date. According to the QDDP Coordinator, improvement had been seen in the timeliness of QDDPs completing the final ISP documents. Although not completely resolved, problems with filing the final document were contributing to the finding that ISPs were not available in the active records within 30 days. Based on discussion while the Monitoring Team was on site, although the ISP documents were electronically available in a shared drive once the QDDPs finalized them, the shared drive was not available to all team members. This issue required further work to identify a solution to ensuring that staff responsible for implementation of the ISPs had access to them to begin implementation within 30 days. As is noted in other sections of this report, IDTs did not consistently make changes to	Noncompliance

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		ISPs for individuals who experienced changes in status, or whose circumstances should have resulted in modifications being made (e.g., for individuals who were hospitalized due to changes in status). Although CCSSLC was consistently completing ISPs within 365 days of the previous meeting, they needed to ensure they were available for implementation within 30 days, and make changes to ISPs as dictated by individuals' needs. The Facility remained out of compliance with this provision.	
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.	Progress had been sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement. Positive aspects of the process included: ▪ DADS Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ Since the last review, the Facility had revised its policy on Quality Assurance for Section F. Policy F.13, revised draft dated 3/7/13, provided some additional detail about the roles and responsibilities of the staff at CCSSLC with regard to monitoring ISP meetings and documents. ▪ CCSSLC was conducting reviews/audits of ISPs using the Individual Support Plan Meeting/Documentation Monitoring Checklist. The Facility had continued to update this form. Revisions were made in June 2012, and again in November 2012. The Facility had been using some version of this form since July 2012. The audit tool focused on pre-meeting activities, the ISP meeting, and the ISP document. Based on a review of the document, it included many important questions/probes that should be helpful in identifying areas of best practice, as well as areas requiring improvement. As noted in the last report, the only caution would be that those implementing the form consistently look for quality. This will be important for some of the questions that are worded: "Did the team… (e.g., discuss action plans or integrated health plans, or review and approve the psychiatric treatment plan)." It would be possible to answer these questions "yes" or "no" without evaluating the quality of the discussion or reviews, which would result in limited valuable information. It would be helpful to define the standards being used for many of the indicators in the tool. ▪ A Program Compliance Monitor from the QA Department, as well as the QDDP Coordinator were conducting the reviews. At the time of the review, the QDDP Coordinator was conducting four audits a month, and the PCM was conducting two per month. Based on review of a sample of completed audit tools, Facility staff responsible for these audits appeared to be making efforts to conduct	Noncompliance

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		thorough and critical reviews, and provide justification for both negative and positive findings. ▪ The PCM had converted the audit tool into an Excel format. This allowed easier manipulation of the data, and should facilitate ongoing analysis of the data. ▪ As noted in other subsections of this report, the Facility also had mechanisms in place to collect other relevant data, such as the timeliness of the submission of assessments, and attendance at ISP meetings. The QA/QI Council was reviewing this information regularly. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ For the audit tool, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QDDP Coordinator) responsible for conducting audits. Facility staff were actively working on this piece. In September 2012, a different PCM had been assigned to this section. Since then, the PCM and QDDP Coordinator had been holding consensus meetings to discuss monitoring results. Based on interview with staff, they had been looking more at their methodologies. The addition of instructions/guidelines, including methodologies as well as standards, will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ In response to a request for reports showing analysis of monitoring/audit data, as well as descriptions of actions taken or corrective action plans developed, the Facility submitted a document entitled "Compliance & IRR Scores – Section F" for September 2012 through November 2012, as well as January 2013 through March 2013. The corrective action plans submitted largely related more directly to Section S. On a positive note, the reports summarized data from both the QDDP Department and the QA Department. They provided data in graph format, and also summarized the data from the audit tools, as well as the inter-rater reliability scores. At the end of the reports, a summary was provided. For the September through November data, the analysis and recommendations largely addressed issues related to inter-rater reliability. The summary of the January through March data provided more information about the findings from the audits. Although the majority of the summary was a description of the data (i.e., numbers of the samples that met the requirements), some limited analysis of the data was beginning to be conducted. At the time of the Monitoring Team's review, the recommendation section had not been completed for this more recent report. Although progress had been made, further work was needed to analyze the data, and develop and implement action steps to address concerns identified.	

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		It was positive that a format had been set up for these reports, data was being collected, and some analysis had begun. However, more work was needed to ensure reliability of the data, and fully utilize the data for quality assurance purposes. The Facility remained out of compliance with this provision.	

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

1. As necessary and appropriate, as the QDDP Coordinator completes competency checks for all QDDPs, QDDPs should be provided with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process. (Section F.1.a)
2. As teams move forward with the implementation of the new ISP Preparation meetings, teams should provide an explanation of their decisions related to team member attendance at the annual ISP meetings, particularly when an individual has a need in a specific area, and the team decides that the attendance of the team member with that area of expertise is not required. In this case, the specific reasons that an assessment is sufficient need to be provided, or a further explanation of the individual's status or lack of needs in a specific area is necessary. Although this is an issue that should be carefully coordinated with the State Office, now that risk levels are being established for individuals, this might be one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. (Section F.1.b)
3. Assessments should include a full set of recommendations that are designed to assist the teams in developing action plans that describe the array of protections, supports and services that the individual requires. As appropriate, assessments should recommend specific areas of focus for skill acquisition programs, as well as detail data that needs to be collected and roles and responsibilities of various staff. (Section F.1.c)
4. Now that the ISP process includes an annual review of incidents, and A/N/E allegations, teams should adequately consider how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
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' ISPs. This should include ensuring that assessments consistently and concisely identify individuals' strengths, needs, and preferences. (Section F.1.c)
6. When an individual has needs in a particular area, but the team is not requiring an assessment, the ISP Preparation Meeting documentation should include a justification that specifies the team's reasons for it decision. (Section F.1.c)
7. 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 ISPs, while focusing on the individual and his/her preferences, strengths, etc. (Section F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
8. IDTs should integrate the recommendations from assessments into ISPs, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the ISP, rather than stand-alone documents. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
9. Team members should be provided ongoing training and technical assistance on the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences, strengths, and needs, and to identify and overcome barriers. (Section F.2.a.1)

10. The Facility should address barriers such as transportation, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups. Individuals' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
11. IDTs should complete additional training and/or be provided technical assistance on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, F.2.a.6, and F.2.e)
12. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
13. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. (Section F.2.a.5)
14. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that ISPs and all of their various components are comprehensible, while still containing the necessary clinical requirements, and that they clearly delineate the roles of direct support professionals. (Section F.2.c)
15. As the Facility finalizes its monthly review process, it should ensure that the following basic requirements are met:
    a. It includes a process for each team member to conduct monthly reviews of the programs which he/she is responsible that results in easy access for all team members to the information;
    b. Monthly reviews should incorporate data, as appropriate, to allow the QDDP and the team to assess the efficacy of the plans and programs in place, and determine if changes are needed, staff need to be retrained, more monitoring needs to occur, etc.; and
    c. QDDPs should document clearly follow-up activity and/or changes that are made to ISPs as a result of these reviews. (Section F.2.d)
16. As previously recommended, as the facilitation skills performance tool evolves:
    a. The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified.
    b. Guidelines should be provided as necessary to support reviewers' understanding of the indicators.
    c. Two areas related to quality that should be added to the checklist include the QDDP's ability to: solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. (Section F.2.e)
17. QDDPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate ISP 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. (Section F.2.e)
18. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new ISP process, as well as to enhance the various team members' skills. (Section F.2.e)
19. Consideration should be given to adding examples of ISPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QDDPs and teams what is expected. (Section F.2.e)
20. With regard to the process of determining whether or not QDDPs are competent with regard to meeting facilitation skills, Facility policy and/or procedure should set forth the parameters with regard to actions that will be taken to assist QDDPs who do not originally meet the competency requirements, as well as other steps that would need to be taken if competency could not be achieved. (Section F.2.e)
21. With regard to the draft Individual Support Plan cycle training, as the training is piloted, consideration should be given to further defining

direct support professionals' specific roles in the various parts of the process, including examples of how their full participation is beneficial, and their lack of participation could have negative effects on the quality of the process. (Section F.2.e)

22. The Facility's QA processes with regard to ISPs should be refined by adding instructions as appropriate (i.e., methodologies and standards), training auditors on their use, establishing inter-rater reliability, ensuring the accuracy of monitoring results, fully analyzing data, and developing and implementing corrective action plans, as appropriate. (Facility Self-Assessment and Section F.2.g)

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 Presentation Book for Section G; o For medical morning meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for the following dates: 3/25/13 to 3/29/13; o For hospitalizations in the previous six months, copies of follow-up ISPAs for the following individuals (with date of hospitalization): Individual #255 8/2/12, Individual #182 1/25/13, Individual #184 11/21/12, Individual #126 12/9/12, Individual #223 11/5/12, Individual #260 10/21/12, Individual #235 8/6/12, Individual #278 12/5/12, Individual #167 11/5/12, Individual #340 10/2/12, Individual #340 10/29/12, Individual #340 12/6/12, Individual #275 1/8/13, Individual #144 1/28/13, Individual #267 11/1/12, Individual #89 1/12/13, Individual #43 12/21/12, Individual #194 11/6/12, Individual #194 12/29/112, Individual #304 1/30/13, Individual #159 8/31/12, Individual #189 11/1/12, Individual #326 1/7/13, Individual #210 9/3/12, Individual #24 9/2/12, Individual #270 7/12/12, Individual #305 11/8/12, Individual #158 9/12/12, Individual #155 11/29/12, Individual #155 1/14/13, Individual #299 12/19/12, Individual #327 12/13/12, Individual #34 11/3/12, Individual #321 12/13/12, Individual #350 11/13/12, Individual #127 8/9/12, Individual #127 11/9/12, Individual #127 1/22/13, Individual #357 9/21/12, Individual #357 10/8/12, Individual #357 10/24/12, Individual #378 8/7/12, Individual #378 9/30/12, Individual #234 12/27/12, Individual #332 10/29/12, Individual #245 11/30/12, Individual #156 10/26/12, and Individual #156 12/31/12; o For one individual from each residence, copies of all consultant reports (i.e., medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPNs) commenting on consultant reports (i.e., medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISP addendum related to the consultant report for: Individual #38, for Gynecology 11/7/12, and Ophthalmology 10/22/12; Individual #334 for Ophthalmology 10/29/12; Individual #44 for Cardiology 10/17/12; Individual #298 for Gynecology 8/3/12; Individual #254 for Ophthalmology 11/12/12; Individual #243 for Ear Nose Throat (ENT) 8/20/12, and Podiatry 10/22/12; Individual #283 for Urology 8/20/12; Individual #95 for Ophthalmology 8/29/12, and ENT 11/14/12; Individual #10 for Ophthalmology 9/27/12, and Urology 9/11/12; Individual #141 for Podiatry 11/14/12, Urology 10/26/12, Ophthalmology12/3/12, and Cardiology 8/6/12; and o Presentation Book For Section G. ▪ **Interviews with**:

	○ Ingela Daniellsson-Sanden, MD/PhD-MBA, Medical Director.
	Facility Self-Assessment: For Section G, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools to conduct the self-assessment. A review of the Facility Self-Assessment included the following: the monitoring/audit templates and the instructions/guidelines required to appropriately complete the tools, a sample of completed monitoring/auditing tools, inter-rater reliability data, and interviews with staff. ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: attendance tracking for several inter-disciplinary committees, post-hospitalization ISPAs, consult tracking, and follow up of recommendations by PCP and IDT. ○ These monitoring/audit tools contained adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. ○ The monitoring tools included adequate methodologies, such as record reviews. ○ The monitoring tools identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate and considered representative. ○ The following personnel were responsible for completing the monitoring tools: the Medical Department and external peer reviewers, and the Facility staff for activities outside of the Medical Department. ○ Adequate inter-rater reliability had not been established between the various Facility staff responsible for completing the tools. ▪ The Facility used some other relevant data sources that showed whether or not the intended outcomes of the Settlement Agreement were being reached. ○ The quality of the data maintained in the databases was noted to be complete and accurate. ○ However, examples of databases/data sources not considered included information derived from the Integrated Clinical Services committee meetings, and active record reviews. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Consistently presented findings based on specific, measurable indicators. ○ Consistently measured the quality as well as the presence of items. ○ Distinguished data collected by the QA Department versus data collected by the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section G. This was consistent with the Monitoring Team's findings. ▪ The Facility Self-Assessment data did identify some areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information. For example, the Facility identified the need for a continued review of consultant recommendation

	follow-up with PCPs through to the IDT process.
	Summary of Monitor's Assessment: The Medical Department and Facility had made progress in tracking attendance at interdisciplinary meetings. At the Integrated Clinical Services meeting, participants included the required departmental representation, but attendance varied across the disciplines. A focus on the prevention of repeat hospitalizations and ER visits, and the necessity for active record/open record reviews was needed. Based on observations, during the meetings, few questions regarding needed follow-up were asked. The meeting minutes did not capture critical discussion that may have occurred. ISPA reports were returned several days later, and focus should be given to a more rapid response to the Integrated Clinical Services Team request for an IDT meeting to address concerns. A valuable monitoring tool was completed for one individual post hospital, but it was unclear whether or not a structure was in place to respond to the findings. Further direction is needed regarding the areas to be addressed in post hospital ISPAs. Additionally, quality monitoring of ISPAs is necessary as in some cases, some of the data had not been analyzed, but instead raw data had been submitted. Consultant reports appeared to be reviewed and acted upon by the PCPs. Follow-up of consultation recommendations for review by the IDT, and ISPA development and implementation remained a challenge. The Facility remained in noncompliance 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.	A sample of provider morning meeting minutes was submitted. The dates of these meeting minutes were from 3/25/12 to 3/29/12. The number of meeting minutes totaled five. The following information summarizes the contents of these meetings: ▪ Zero of five meetings (0%) recorded attendance. ▪ Five of five (100%) included discussion of the Campus Coordinator Log. ▪ Five of five (100%) included discussion of the on-call provider report. The number of cases discussed per day varied from three to nine. ▪ Five of five (100%) included a report by the Hospital Liaison Nurse. ▪ Five of five (100%) included an Infirmary Report. The daily census for the Infirmary varied from three to four individuals each day. ▪ Zero of five (0%) discussed specific measures to prevent additional hospitalization/ER visits for four individuals hospitalized or two individuals taken to the ER during this time period. Additionally, one individual was discharged from the hospital and admitted to the Infirmary. ▪ Zero of five (0%) appointed a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit. ▪ One of five (20%) included a discussion of the results of an open record review.	Noncompliance

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		o A document entitled "Hospitalization Prevention Tool/Instructions" was submitted. This document was completed by an RN and dated 3/24/13. The document reported on a record review for an individual hospitalized with pneumonia. Pertinent findings included the answers to the following probes/indicators: (4a) Performing appropriate assessments as dictated by the affected and related system(s): No; (4d) Monitor individual's health care status sufficient to readily identify changes in status: No; (4e) Creating/modifying a nursing care plan as needed to address changes in the individual's condition: No; (4f) Implementing a nursing care plan as needed to address changes in the individual's condition: No; (5) Following the initial evaluation/assessment of an actual or potential acute illness/injury, the licensed nursing staff closely monitored the individual (in alignment with the presenting condition): No; (7a) There is evidence that the direct care professional staff was trained in the recognition of changes in health status which may indicate acute illness/injury: No; and (8) There is evidence that the nursing staff communicated to all direct support staff and oncoming nursing staff their monitoring and follow up responsibilities: No. The summary question was (9) Does the team feel that this could have been prevented? (a) If so, was a system problem that requires a Corrective Action plan? Yes – no nursing care plan implemented on the home. Licensed Vocational Nurse (LVN) did not document their assessment (b) or staff education? No – direct support professional (DSP) reported concerns to the nursing staff. This was valuable information for the PCP. It was not clear whether or not an action plan was created and implemented by the Nursing Department. ▪ Three of five (60%) included identification of concerns needing closure and assigning tasks. This included a request for IDTs to create ISPAs for two individuals. ▪ One of five (20%) included additional information provided through a Medical Director announcement. ▪ Two of five (40%) included discussion and resolution of closure items. There were four closure items reviewed. ▪ One of five (20%) reviewed ISPAs as part of the closure process at the medical morning meeting. A total of two ISPAs were received. ▪ Two of two (100%) ISPAs were approved/accepted by the medical morning meeting as appropriately addressing the concern directed to the IDT. ▪ Zero of five (0%) meetings reviewed consult reports. ▪ There was no report of scheduled consults missed. ▪ One of five (20%) recorded a PNMT report. ▪ Zero of five (0%) recorded updates regarding individuals receiving	

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		medical/dental restraints. ▪ Zero of five (0%) recorded a skin integrity report. ▪ Zero of five (0%) recorded a report of any individuals with significant weight gain or loss. ▪ Zero of five (0%) included a discussion/in-service of systemic medical concerns, policies or procedures, quarterly analyses of data, etc. ▪ Two of five (20%) reported an infection control concern. The integrated clinical services committee provided a forum for review of ISPAs from the IDTs in responding to requests and concerns of the integrated clinical services committee. This appeared to be in place, although the timeliness for the IDT to meet and respond with an ISPA did not meet the guidelines of Section I (i.e., At-risk Individuals). Several ISPAs for individuals hospitalized remained outstanding in the minutes of this committee. The "Hospitalization Prevention" audit tool was utilized during the week for which minutes were provided. The components of the tool provided valuable insight of the care at the residences. The focus was on nursing care along with direct support professional training and care. However, it was not clear who was responsible for any corrective actions that needed to occur based on this report. The above referenced report was also the only example provided, indicating it might not be routinely used at the time of the Monitoring Team's visit. This report indicated the date of hospitalization for the individual was 1/22/13, but the report was not completed or referred to the PCP until the week of 3/25/13. The individual was discharged from the Infirmary to the residence on 1/31/13. The information from this report would have been useful to the IDT on the day the individual returned to the residence. The reason for the delay in reporting was not reviewed. The ISPA for the individual was dated 2/7/13, and reflected clinical concerns that might have contributed to the hospitalization and/or admission to the Infirmary. This listing was helpful in guiding the team and a detailed discussion was reflected in the ISPA. A goal for the QDDP would be to ensure that the issues listed in the above "Hospitalization Prevention" report were addressed and incorporated into the ISPA, and that critical thinking occurred and was reflected in the decisions of the team. Given the individual's history of hospitalization for aspiration pneumonia, the choice of bolus feeding versus intermittent feeding was not further discussed. There was no discussion as to the impact of GERD (listed as an issue) and how this might contribute to future aspiration pneumonia. The individual had sleep apnea and used Continuous Positive Airway Pressure (CPAP), but there was no discussion as to how frequently the individual was monitored to ensure the apparatus was in place, and there was no monitoring discussed concerning pulse oximetry. There was a new diagnosis of pre-diabetes, but there was no discussion from dietary confirming whether the rate of	

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		formula and amount per day was optimal, nor was there discussion on the frequency of monitoring blood glucose. The individual had been on steroids for a period of time, which can aggravate the blood glucose, but this was not listed as an issue. The diagnosis of allergic rhinitis was listed as a contributing issue, but there was no discussion concerning environmental issues (i.e., home cleaning chemicals, level of dust, etc.). These components required the attention and discussion by a variety of clinical disciplines. It appeared that the tools were in place at CCSSLC for this to occur, but the process was still in the formative stage of development. The Facility submitted ISPAs for hospitalizations that occurred during the six months prior to the Monitoring Team's review. Hospitalizations involved 48 admissions. These were reviewed to determine the reason for hospitalization, evidence of a record review for events prior to the hospitalization, evidence of identification of new triggers as early signs and symptoms of illness, evidence of recommendations to increase monitoring of specific parameters, and additional steps implemented to reduce the risk of recurrence of illness and hospitalization. Several individuals had more than one hospitalization, and measurements did not separate out the various admissions per individual. However, all documentation submitted related to the hospitalizations was used to monitor the quality of the team approach to resolving health care issues to address the cause of the hospitalization or repeat hospitalization. Based on the clinical needs of the individual, not all individuals required additional action steps/processes as part of the IDT review. However, the IDTs did demonstrate one or more processes in a number of cases. The findings included the following: ▪ 41 of 48 (85%) had an ISPA developed post hospitalization. ▪ Zero of 48 (0%) referenced a documented record review/open record review. ▪ One of 48 (2%) contained notations of new triggers or early signs/symptoms identified by the IDT. ▪ 20 of 48 (42%) of the IDTs identified the need for increased monitoring in one or more aspects of care. ▪ 20 of 48 (42%) of the IDTs identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization. ▪ Two of 48 (4%) of the ISPAs were submitted within five days from the start of hospitalization to the creation of the initial ISPA. o The timely response of the IDT was measured from the start of the hospitalization to the completion of the ISPA. The following represents the number of ISPAs completed in each seven day interval: ▪ One to seven days = four ISPAs; ▪ Eight to 14 days = 10 ISPAs;	

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		▪ 15 to 21 days = nine ISPAs; ▪ 22 to 28 days = seven ISPAs; and ▪ More than 28 days = nine ISPAs. It was observed that many IDTs did not meet until after the individual returned to CCSSLC, and only when the individual returned to the residence. If the individual was admitted from the hospital to the Infirmary, there appeared to be a delay in ISPA development. However, the period of time directly following the hospital admission date represented a time frame in which a record review could be completed, and the team could meet with direct support professionals to determine whether any subtle changes in health status could be identified, information that may be forgotten with the passage of time and should optimally be captured within a short time of admission. The Facility submitted information regarding closure concerns discussed at the Integrated Clinical Services Team meeting held each morning during business days. The submitted documents included 15 closure concerns for 13 individuals. The document used for evidence of closure was email in six cases and ISPAs in nine cases. Length of time to closure varied from one day to 82 days. Time to closure was as follows: ▪ One to five days – three concerns; ▪ Six to fifteen days – three concerns; ▪ 16 to 30 days – four concerns; and ▪ More than 30 days – four concerns. One concern remained outstanding with no submitted information concerning closure. Areas of concern included dietary issues, nursing concerns, pica, falls, and complications of behaviors. The Integrated Clinical Services Team accepted nine closures. In addition, four concerns were reviewed by the ICST, but there was no verification of closure. One item was no longer applicable as the employee to be trained no longer worked at CCSSLC. One concern from 12/12/12 remained outstanding. It was noted that the ICST returned three responses for further review during this process of ensuring appropriateness of closure. The Facility tracked attendance at the Integrated Clinical Services meeting. Summary information was provided in chart format, listing for each month, the percentage of meetings attended for each department. Data was provided for the months of August 2012 through January 2013. PCPs and Nursing Department attended 100 percent of the time. Dental Department attendance varied from 82 to 100 percent. Pharmacy Department attendance varied from 82 to 100 percent. Habilitation services/PNMT attendance varied from 50 to 78 percent. Psychology Department attendance varied	

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		from 41 to 87 percent. Psychiatry Department attendance varied from 43 to 73 percent. The QA Department began to attend in October 2012 and attendance per month varied from zero to 31 percent. The QDDP Department also began to attend in October 2012 and attendance per month varied from zero to 57 percent. The Facility also tracked other interdisciplinary meetings for representation from key departments and services. Submitted were percentage attendance by departments for the Infection Control meeting, attendance numbers by department for the Skin Integrity meeting, Pharmacy and Therapeutics (P&T) Committee, the Medication Error Committee, and raw data from various PNMT meetings. This data appeared to provide the necessary information in determining whether appropriate departments were represented at these various meetings. There was no information on how Facility Administration used this information, such as frequency of review, and action steps that may have been taken in response to analysis of this information. The raw data from the various PNMT meetings was a challenge in determining trends, and it is suggested that this be reduced to percent attendance by required departments. The Facility also tracked attendance at ISPs, and samples of attendance tracking were submitted for ISP meetings, which included a breakdown of those required to attend and those that attended, but were not required. A sample was provided that listed ISP meetings from 1/29/13 to 3/8/13, along with the departments and clinical services in attendance. A percentage attendance of required attendees was calculated for each ISP. The percentage attendance of required attendees for these meetings ranged from 50 to 100 percent. Although CCSSLC had made progress in this area, the Facility remained out of compliance with this provision. The challenge in demonstrating integrated clinical care was several-fold. Increasing the breadth of the ICST's morning meeting will be important. From the Monitoring Team's review, the IDTs needed continued guidance and accountability, and an expansion of open record reviews to determine early signs and symptoms helpful in treating illness at an early stage. For the ISPAs that were the written response to a concern assigned to the IDT, there was need to determine if the ICST participants agreed or not with the ISPA (i.e., did it satisfactorily answer the concern). Critical questions needed to be asked and answered at the ICST meetings and by the IDTs. As discussed in previous reports, each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus.	
G2	Commencing within six months of the Effective Date hereof and with	Consultant reports for one individual from each residence were requested, as well as any IPNs commenting on the consultant reports and ISPAs written in response to the	Noncompliance

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	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.	consultant report. Consultations for 10 individuals were submitted, with a range of one to four consultations per individual. A total of 17 consultant reports were submitted and these are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 17 reviewed, 17 (100%) included the PCP initials, indicating review by the PCP. ▪ Of the 17 reviewed, 17 (100%) included the date on which the PCP conducted the review. ▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. o Of the 17 reviewed, 16 (94%) consults included documentation of agreement or disagreement with the consultant recommendations. o Of these 17, 14 (82%) included PCP IPN entries. o There was a "consultant recommendation review" sign in sheet by IDT members for four (24%) of the 17. Of these, one ISPA was generated. The IDT determined an ISPA was not needed for three of the four. o Of these 17, the consultant reports indicated potential need for ISPAs in four cases. Of these four cases submitted, the information documented creation of one (25%) ISPA. This indicated the IDTs might need guidance on when an ISPA would benefit the individual and the need for a systemic approach in creating this structure. IDTs need to also be monitored to ensure ISPAs are being created when applicable. The Medical Department also utilized an audit tool entitled "Section G: Monitoring Tools," which monitored the follow-up of consultant reports, including whether the IDT was informed of the results of the PCP's review. It also reviewed whether the recommendations from the consultation were integrated into the ISP/ISPA as appropriate. The amount of information completed on each of these audits varied by reviewer. For some reviews, there were considerable, detailed comments. For others, there were no comments. It is recommended that there be guidelines developed and training regarding the expectations in completing this tool. When completed correctly, this information provided data needed to ensure timely and appropriate response to consultant recommendations. A Consultant Recommendation Review form listed the specific consultation, and was signed by each of the IDT members that reviewed the consultation, with the date of review. Whether an ISPA was required or not was also indicated. This form tracked the consultant recommendation from the Medical Department to the IDT to ensure the appropriate review of information. The Facility remained out of compliance with this provision. This was due to the lack of	

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		PCP IPN entries, as well as ISPAs for individuals for whom this was indicated based on the recommendations in the consultations.	

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

1. An active record review is recommended for any acute illness resulting in a hospitalization. The focus of the review is to determine early warning signs and symptoms of illness, to determine what action steps were taken during that time, and to determine the quality of documentation. This might also apply to certain types of ER visits, particularly those for acute illnesses. This would potentially lead to new triggers or identification of signs or symptoms early in the course of illness. It might lead to identification of additional/different direct care or nursing actions or assessments, diagnostic and therapeutic steps, and monitoring needed to ensure adequate care and to prevent recurrence. (Section G.1)
2. The "Hospitalization Prevention Tool" audit is indicated for any acute illness hospitalization. This would have greatest impact if completed prior to the IDT meeting for an ISPA, so information can become part of the ISPA. There should be demonstration of corrective action plans and follow-up monitoring to resolve findings from this audit mechanism. (Section G.1)
3. Issues contributing to a hospitalization should be listed in bullet format for the post hospital ISPA, and each issue should be addressed in the ISPA. (Section G.1)
4. IDTs should meet to begin to complete ISPAs as soon as hospitalizations for acute illness occur. This is the time period when direct support professionals, nursing staff, and other personnel would recall nuances of changes in an individual's behavior or function, helpful in early identification of a concern. Important details of actions and events might clarify steps that worked or additional steps that might be needed. (Section G.1)
5. The raw data from the various PNMT meetings should be analyzed and summarized in percentage attendance per discipline. (Section G.1)
6. A Facility systems approach should be developed that would guide the IDTs in determining when an ISPA would benefit the individual based on the results of a consultation. A monitoring system also should be developed to ensure ISPAs are being created when applicable. (Section G.2)
7. For consistency of content and value of the "Section G: Monitoring Tools," there should be guidelines developed and training of expectations in completing this tool. (Section G.2 and Facility Self-Assessment)

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 the following documents: o Presentation Book for Section H; o For four of the most recently completed annual medical evaluations/assessments of individuals from each PCP's caseload. A copy of the active problem list, with identification of four significant diagnoses, and criteria/evidence for justification from the active record for each diagnosis, for the following individuals: Individual #379, Individual #48, Individual #182, Individual #297, Individual #31, Individual #223, Individual #260, Individual #244, Individual #279, Individual #104, Individual #70, Individual #210, Individual #155, Individual #166, Individual #187, and Individual #95. ▪ Interviews with: o Ingela Daniellsson-Sanden, MD/PhD-MBA, Medical Director.
	Facility Self-Assessment: When conducting its self-assessment for Section H, the Facility used monitoring/auditing tools. Evaluation of the Facility's Self-Assessment included review of the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff. ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included the following: quality indicator monitoring of ER/hospitalizations, osteopenia and osteoporosis, hypertension, diabetes mellitus, metabolic syndrome, Down syndrome, constipation, and seizures. o These monitoring/audit tools included some indicators to allow the Facility to determine compliance with some aspects of the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ The monitoring tools included adequate methodologies, such as record and database reviews. ▪ The Self-Assessment identified the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample size(s) were adequate to consider them representative samples. ▪ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures that showed whether or not some of the intended outcomes of the Settlement Agreement were being reached. For example, it tracked the completion of annual medical assessments, and the completion of quarterly medical reviews. ▪ The quality of the data maintained in the databases was noted to be complete and accurate. The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-

	Assessment presented findings consistently based on specific, measurable indicators. The Facility rated itself as being in compliance with Section H.2. This was consistent with the Monitoring Team's findings. The Facility data identified some areas of need/improvement. For those areas of need, the Facility Self-Assessment provided some limited analysis of the information, identifying for example the need for further monitoring of quality care of specific diseases/diagnoses.
	Summary of Monitor's Assessment: The Facility continued to monitor routine assessments. Each department was at a different level of compliance. Dental annual evaluations and QDRR completion was timely. Medical annual assessments and quarterly medical reviews remained noncompliant. There was no data for assessment of quality medical care concerning health status change. However, the documentation in the Integrated Clinical Services Team meeting provided important information from which measurable indicators have the potential to be developed for this purpose. The medical and psychiatric diagnoses in the active records were based on appropriate criteria. The Facility was found to remain in substantial compliance with Section H.2. The external and internal medical peer review audits had the potential to be used to measure timely and appropriate treatment, although these were limited in scope. However, from the data submitted, it was difficult to confirm the statistics provided. As mentioned with regard to Section L.3, much of the December internal audit was not submitted. However, although gathering data is essential, it is only a beginning step in the process of improving medical care. Analysis and actions based on analysis should occur in a timely manner, along with the documentation to track progress. These steps appeared lacking. The Medical Department and QA Department need to review their responsibilities in analysis and implementation of improvement plans. Sections H.3 to H.7 require systems development of quality improvement and monitoring to ensure the health of individuals residing at CCSSLC. The external and internal medical peer review audits are a first step in that process. The Facility will need to demonstrate that the data has resulted in improvement. It will also need to create other tools to measure quality of care to cover the many aspects of medical and health services.

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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	Several routine and periodic assessments were reviewed for timeliness within the documents submitted from several clinical departments. These included the following: ▪ 138 of 248 (56%) medical annual assessments reviewed were completed in a timely manner. ▪ 172 of 368 (47%) of quarterly medical reviews were completed in a timely manner. ▪ 141 of 142 (99%) dental annual evaluations were completed in a timely manner.	Noncompliance

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	individual's status to ensure the timely detection of individuals' needs.	▪ 572 of 591 (97%) QDRRs were completed in a timely manner. According to the Action Plan for Section H, trend analysis of annual and quarterly assessments had not begun. The Medical Department was able to track completion of annual medical assessments, as well as quarterly medical assessments. The Facility tracked departmental assessments/reports submitted for review prior to the ISP. Fifteen reports were tracked from the departments important to the ISP process. For each page of data submitted, percentage compliance with timely completion was calculated. From the list of submitted data, for the 10 most recent ISPs scheduled in February 2012, the compliance varied with departments. Psychiatry submitted zero of two reports (0% compliance). The medical assessment was timely in five of 10 (50%), and psychological evaluation was timely in six of 10 reports (60%), Dental Services was 100 percent compliant, Pharmacy Services was 100 percent compliant, and Nursing Services was 90 percent compliant. Timeliness of assessments for ISPs is discussed in further detail with regard to Section F. In response to developments or changes in an individual's health status with a subsequent ER visit, the active medical record included PCP IPN assessments documenting the change in one of one (100%) record reviewed. For nine of 10 submitted cases with ER visits, the PCP was not on site at the time of the emergency transfer. On return from a hospital admission, there was a PCP IPN in 10 of 10 (100%) cases, summarizing the hospitalization, and reviewing any recommendations and/or change of health status concerns. Due to the small sample size, assessment of timely evaluation by PCPs of health status change for those needing ER care could not be determined from the information provided. However, nursing assessments of changes of status resulting in hospitalizations remained problematic. This is discussed in detail with regard to Section M.1. The Integrated Clinical Services Committee reviewed all health status changes every weekday. The minutes documented calls to the on-call PCP, and information was provided the following morning by the on-call PCP. A campus log documented all activity and concerns during the prior 24 hours. Those in the Infirmary were reviewed with clinical detail summarized. The information indicated that health status changes, once recognized, were tracked each day until resolution. Depending on the health concern, attendees provided information and recommendations for diagnostic or treatment needs. Less clear was the time period leading up to the recognition of the acute illness. The one open record review the Facility submitted to the Monitoring Team indicated that	

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		nursing services had not completed appropriate nursing care plans for a health status change, and had not trained the direct support professionals on how to care for the individual with a change in health status. The Facility remained out of compliance with this provision. Although some annual and quarterly assessments were timely, others were not. In addition, assessment of changes of status, particularly with regard to nursing services, remained a significant concern.	
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.	A sample of diagnoses listed in individuals' active problem lists was submitted. The sample was derived from four active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. The PCPs were asked to provide the criteria or evidence used to determine whether the diagnoses clinically fit the information in the corresponding assessments or evaluations. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). For 62 of 64 (97%) of the diagnoses submitted with supportive documentation, the criteria listed were consistent with the diagnosis listed. Submitted information indicated there were no in-service training sessions for ICD and DS diagnostic criteria in the Medical Department during the prior six months. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed for Section J, there was adequate clinical justification for the diagnosis of record for 18 of the 18 individuals (100%). With the completion of Comprehensive Psychiatric Evaluations and ongoing quarterly updates for everyone prescribed psychotropic medication, the Facility had maintained the improvements in its diagnostic practices related to psychiatric disorders. Based on the consistency between the diagnoses and the assessment documentation for both medical and psychiatric diagnoses, the Facility remained in substantial compliance with this provision.	Substantial Compliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The external and internal general medical audits and medical management audits provided a mechanism to conduct systematic review of appropriate and timely treatment based on measurable criteria. The external medical management occurred once in the prior six months. Management of three common diagnoses (i.e., constipation, seizures, and urinary tract infections) was reviewed as part of the medical management audit (as discussed in further detail with regard to Section L.2). However, the data was not analyzed into essential and non-essential components to determine which indicators were problematic. It did not list indicators for which there was the greatest need of improvement. The internal medical peer review was also problematic (also discussed with regard to Section L.2). When corrective actions were identified, there appeared to	Noncompliance

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		be no system to ensure resolution in a timely manner and concerns remained unresolved. There was no information provided indicating that results had been discussed with the PCPs, or trends of serial audits assessed. There was documentation from the external medical peer review audit concerning a written report of findings. The external and internal medical peer review general medical and medical management audits provided a methodology to determine whether treatment and interventions were timely and appropriate. However, there was no documentation of follow through to ensure discussions were held with the medical staff, steps taken to ensure timely resolution of corrective action plans, nor identification of strengths and weakness, and development of systems of clinical care improvement. In addition, these audits only covered a limited number of diagnoses. The Facility remained out of compliance with this provision.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The Medical Department submitted raw data from an audit entitled "Quality Indicators for ER/Hospital Visits." Sixteen forms that had been completed from 11/18/12 to 1/21/13 were submitted. Raw data was submitted from an audit entitled "Quality Indicators for Osteoporosis" for 12 reviews completed from 11/16/12 to 1/20/13. Raw data was submitted from an audit entitled "Quality Indicators for Metabolic Syndrome" for two reviews completed from 1/20/13 to 1/21/13. Raw data was submitted from an audit entitled "Quality Indicators for Hypertension" for 12 reviews completed from 11/18/12 to 1/21/13. Raw data was submitted from an audit entitled "Quality Indicators for Diabetes" for 12 reviews completed from 11/18/12 to 1/21/13. Raw data was submitted from an audit entitled "Quality Indicators for Constipation" for 12 reviews completed from 11/18/12 to 1/21/13. Raw data was submitted from an audit entitled "Quality Indicators for Seizures" completed from 11/16/12 to 1/21/13. Raw data was submitted from an audit entitled "Quality Indicators for Down Syndrome" for two reviews completed from 1/20/13 to 1/21/13. The indicators chosen for each of these audits was "based on recommendations from the Agency for Healthcare Research and Quality and Physician Consortium for Performance Improvement." These appeared to be an important first step in establishing the internal medical audit process. Once initial data is collected, findings will need to be analyzed to identify areas in need of improvement, and potentially action plans to address these areas. Ongoing assessment will be needed to determine whether the indicators need to remain in place or be expanded/changed. If the findings indicated 100% compliance with most or all indicators, then other indicators need to be chosen for continuous quality improvement. There was no information submitted to determine whether or not these raw data were summarized and analyzed, and if the Medical Department had met to discuss results.	Noncompliance

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		There was considerable information gathered for a number of diagnoses, but no baseline data to determine areas of strength or areas needing improvement. Documentation was not submitted with these to indicate the time and date of a medical staff meeting to discuss this information and any systemic initiatives based on the information. The Facility remained out of compliance with this provision. Although it was positive that the Facility had attempted to define clinical indicators, work was needed to utilize the data collected to determine the efficacy of treatments.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A system was in place for quarterly medical reviews, quarterly pharmacy reviews, and quarterly nursing reviews. As discussed in greater detail with regard to Sections L, M, and N, the different departments were at different stages of reaching the goal of campus-wide completion of quarterly assessments. In addition, the at-risk process had not yet developed to the phase of being able to identify and/or monitor the clinical indicators necessary to show whether or not individuals' action plans were successful or to effectively monitor the health status of individuals. The completion of the Integrated Risk Rating Form (IRRF) at the time of the ISP and subsequent changes to IRRF based on ISPAs, as well as requests for review by the ICST would provide opportunities to capture information that demonstrated the health status of individuals was being monitored. Acute health status changes were identified in the ICST meeting. The follow-up to closure, as well as the ISPAs requested and open record reviews also would provide further response to changes in health status to meet the needs of the individual. On a long-term basis for stable conditions, the timely quality reviews as part of monthly, quarterly, or annual reviews/assessments by the various clinical departments would provide evidence for monitoring of the ongoing health of individuals. However, these periodic documents needed to be working documents with accurate and complete data using quality indicators that have measurable components to guide the IDTs in determining whether health is stable or there is need for further intervention, testing, etc. Assessments and integrated health care plans did not yet include these components. This is discussed in further detail with regard to Section I, as well as Sections M and O. As this section was multi-disciplinary, every clinical department should have provided evidence of its participation in ensuring common elements of clinical care were provided to each individual when indicated. One of the areas needing further focus was tracking minimum common elements of clinical care required on an ongoing basis for preventive care and wellness, as well as routine care of diagnoses common to the IDD population.	Noncompliance

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		The Facility remained out of compliance with this provision.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As noted above, the Facility had begun to develop and collect data on a set of clinical indicators. However, evidence was not submitted to show that treatments and interventions were modified in response to clinical indicators. This section will require demonstration of a functional system that is both integrated and provides the full spectrum of all elements of clinical care. The various protocols developed by the State Office represent an initial framework for this section, but there needs to be evidence that these are put into action, and that treatment reflects ongoing interventions and changes in interventions based on identified clinical criteria/clinical indicators that are appropriate for the individual. Discussions at the morning meetings should include reviewing the changes (deterioration) in health status reported. This should lead to a review of current treatment interventions, and discussion of potential modifications guided by the clinical guidelines (and other national professional recommendations, as appropriate). Use of related clinical indicators would be helpful in tracking progress. The external medical peer review audit and the quality indicators in the Medical Department provided information based on clinical indicators. However, as mentioned, there appeared to be no next steps, as the results of the clinical indicator reviews did not appear to be analyzed. There was no information to determine if action steps had been taken based on this information. Where clinical indicators showed gaps in care or documentation of care, there was no information to indicate if these had been resolved, and resolved in a timely manner. The corrective action plans from the external and internal medical peer review were not clearly tracked by date of resolution. Resolution could not be determined for some corrective action plans. Timeliness of resolution was also difficult to track. The Facility remained out of compliance with this provision.	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.	There were no new policies submitted for this section. In attempting to create a system of policies to guide CCSSLC in creating a quality care system, it is recommended that the various policies related to this section that have been discussed in previous reports be mapped to determine areas of overlap, and areas of care that remain without guidance, or have no oversight. The policies developed for integrated care and elements of clinical care appeared to be independent of one another, and it was not clear how they interfaced or potentiated the ultimate goal of integration.	Noncompliance

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		Each was presented as an island (e.g., morning medical meeting, clinic operations, etc.) rather than an essential part of a whole. Providing an organizational flow chart/ladder of how these different policies, if implemented correctly, would assist in refining the integration of care process, would be instructive to the Facility to ensure there are no gaps in the process and all important information is tracked until closure. It is also recommended this same mapping process be completed with committees and other oversight bodies, to ensure all clinical areas have an ongoing monitoring process in place. The QA Department also should develop a monitoring tool measuring effectiveness of these various committees to ensure they are efficient and effective, and provide quality oversight of the clinical areas assigned to them.	

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

1. All clinical areas, including nursing, psychology, psychiatry, habilitation therapy, etc., should provide evidence that routine quality assessments are completed in a timely manner, as well as evidence of timely response to changes in health status of the individual. (Section H.1)
2. The Medical Department should review the findings of the external and internal medical peer review audits and other internal Medical Department audits, document discussions with medical staff, implement timelines by which corrective action plans are resolved, identify areas needing improvement, and develop systems to strengthen the quality of care in these areas. (Sections H.3 and H.4)
3. Changes in health status of the individuals should be tracked by the Facility to ensure all appropriate clinical departments participate in resolving the health concern identified. (Section H.5)
4. The various CCSSLC policies should be mapped to determine areas of overlap, and areas of care that remain without guidance or have no oversight. (Section H.7)
5. The various CCSSLC committees and oversight bodies should be mapped to ensure all clinical areas have an ongoing monitoring process in place. (Section H.7)

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 DADS SSLC revised "Risk Guidelines" laminated record, dated 6/18/12; o CCSSLC's Self-Assessment; o CCSSLC's Section I Presentation Book; o CCSSLC At-Risk Individuals list; o The following documents: Integrated Risk Rating Forms (IRRFs), Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans/Integrated Health Care Plans (IHCPs) for the following individuals: Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior; o For the following individuals' active records, selected documents: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries past one year, ER report past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form past one year, risk action plan past one year for the following individuals: Individual #297, Individual #278, Individual #244, Individual #340, Individual #273, Individual #159, Individual #65, Individual #70, Individual #266, Individual #158, Individual #46, Individual #319, Individual #128, Individual #181, Individual #111, Individual #350, Individual #269, Individual #193, and Individual #332; and o Section I Presentation Book. ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Chief Nurse Executive (CNE); o Angela Roberts, Au.D., Director of Habilitation Therapies (HT); and o Rachel Martinez, QDDP Coordinator. ▪ **Observations of**: o ISP Meeting for Individual #184, on 4/1/13; o ISP Meeting for Individual #91, on 4/2/13; o ISP Meeting for Individual #268 on 4/3/13; and o ISP Meeting for Individual #324 on 4/4/13.

	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. At the time of the review, the Facility was in process of reviewing and modifying its monitoring tool for Section I, to include all the provisions of the Settlement Agreement for the different subsections of Section I. However, based on a review of the Facility's Self-Assessment: o Many of the metrics/indicators used by the Facility for this section, as well as some of the data presented were in alignment with the Monitoring Team's metrics/indicators and findings. As the Facility continues to revise its monitoring tools, the Facility is encouraged to continue to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. In addition, the Facility should include adequate instructions addressing methodologies to be used with regard to specific indicators, such as observations, record reviews, and specific criteria for compliance. Without adequate instructions, it is likely that different auditors would, for example, look at different documents, or different portions of documents in conducting their reviews resulting in inaccurate data. In addition, further definition is needed with regard to the criteria auditors should use to rate the various indicators. Thus, there is a need for clear instructions for all monitoring tools and the establishment of inter-rater reliability to ensure the data generated from the tools are an accurate reflection of the area being audited. o Regarding identifying the sample and sample sizes, a description of the process for determining how the total population from which the samples were pulled (e.g., everyone with a completed risk rating tool, individuals identified with high-risk ratings, etc.) will be necessary to determine the relevance of the data. After clearly identifying the total population (N) used to define the sample selected, (n), an adequate sample size would be needed to consider the data representative of the actual practices being monitored. o Regarding the monitoring for Section I, in order for the Facility to generate accurate data reflecting the clinical quality of the documentation, auditors for this area should be deemed competent in the use of the tools and deemed programmatically/clinically competent in the relevant area(s). As noted during several past reviews and in the Monitoring Team's previous reports, the quality and adequacy of the assessments conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. In order to ensure the accuracy of the data, the Facility should evaluate who would best audit this highly clinical area. At the time of the review, the auditor for this area was not a clinician and candidly reported that some of the Facility's data reflected compliance based on the completion of the documentation rather than on the quality of the documentation. o Adequate inter-rater reliability should be established for the final Section I monitoring tool. ▪ Due to the lack of an adequate written procedure addressing the process of developing and

	implementing monitoring tools, lack of established inter-rater reliability, and overall data presentation, at the time of the review, the Facility did not yet have a consistent system for presenting data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present most findings based on specific, measurable indicators. For example, the Facility needs to be clear regarding what specific criteria had been used to determine compliance. In addition, items contained on the monitoring tool should not include more than one item, such as "objectives within the action plans were measurable and designated a person responsible for data review," making it impossible to determine which of these requirements were found to be in compliance and which had not. o Did not measure the quality of the documentation versus merely the completion of the documentation as noted above. The Facility rated itself as being in substantial compliance with none of the subsections of Section I. This was consistent with the Monitoring Team's findings. However, the Monitoring Team's findings addressed the quality aspect of the documentation reviewed. In reviewing the Monitoring Team's report, the Facility should determine how it will assess quality, and also identify reasons for any compliance score discrepancies found between the Monitoring Team and the Facility's data.
	Summary of Monitor's Assessment: During the previous review in July 2012, the Facility had begun the implementation of the revised At-Risk Process using two teams from 524A and Porpoise. In addition, on 10/4/12 and 10/5/12 competency-based training regarding the Enhanced Risk Rating system was provided with the following positive compliance rates for the disciplines that were required to attend the training: 17 of 18 QDDPs (94%); 14 of 14 Nursing staff (100%); 14 of 19 Habilitation Therapists and Assistants (74%); and 13 of 15 (87%) Psychology staff. In addition, although not required to attend the training, two physicians and one Active Treatment staff member also attended the training. Although the Facility did not indicate what disciplines these data represented, at the time of the review, the Facility indicated that 58 of 66 (88%) of additional staff that were required to attend the training actually attended and passed the Enhanced Risk Process training. The Enhanced Risk Process training was significantly improved since several key components addressing issues such as data, supports, baselines, and specific clinical indicators that were not addressed previously were included in the most current training curriculum. In addition, on 1/25/13, the Facility began using a revised Integrated Risk Rating Form that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating. Regarding some of the Facility's auditing data for Section I, the Monitoring Team noted a positive step forward in that the Facility was incorporating a number of the metrics/indicators the Monitoring Team used for this area, and some of the Facility's data were in alignment with the Monitoring Team's findings. However, the numerous changes that had occurred with regard to the At-Risk system continued to be reflected in the documentation, specifically the varying quality of the IRRFs and the overall poor quality of

	the Integrated Health Care Plans. The overall lack of clear documentation included in the ISPs, the IHCPs, and the associated disciplines' assessments regarding specific actions that were taken in response to pertinent events or health issues, the lack of supporting documentation addressing actions and completion of actions continued to make the Monitoring Team's review of the Enhanced At-Risk system difficult. Although there were some positive observations noted from the ISP meetings the Monitoring Team observed during the onsite review, there continued to be significant problematic issues regarding the accuracy of the risk levels, the reflection in the IHCPs of the necessary clinical intensity to address designated risk levels, the identification of functional and/or measurable objectives, the inclusion of adequate preventative measures, and clear documentation of this process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Since the last review, interviews with the Facility staff, and CCSSLC's Self-Assessment indicated that the following steps had been implemented, and assessments conducted regarding the At-Risk process: ▪ At the time of the previous review in July 2012, the Facility had begun the implementation of the revised At-Risk Process using two teams from 524A and Porpoise. On 10/4/12 and 10/5/12 competency-based training regarding the Enhanced Risk Rating system was provided with the following positive compliance rates for the disciplines that were required to attend the training: 17 of 18 QDDPs (94%); 14 of 14 Nursing staff (100%); 14 of 19 Habilitation Therapists and Assistants (74%); and 13 of 15 (87%) Psychology staff. In addition, although not required to attend the training, two physicians and one Active Treatment staff member also attended the training. Also, at the time of the review, the Facility indicated that 58 of 66 (88%) additional staff that were required to attend the training actually attended and passed the Enhanced Risk Process training. However, no information was provided regarding the disciplines that these data represented. ▪ The Facility's Self-Assessment noted that the quality of the Enhanced Risk Process training was significantly improved since several key components addressing issues such as data, supports, baselines, and specific clinical indicators that were not addressed previously were included in the most current training curriculum. ▪ In addition, the Facility Self-Assessment indicated that on 1/25/13, the Facility began using the revised Integrated Risk Rating Form that included sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating. ▪ The Facility's Self-Assessment indicated that from a sample of eight ISP	Noncompliance

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		Monitoring Observation Checklists (two per month from October 2012 through January 2013) data was generated addressing this provision of the Settlement Agreement. However, there was no indication as to how many total ISP meetings were conducted during the time period to establish the percent sample size and how the particular sample was selected. On a positive note, many of the metrics/indicators the Facility used for this area, and the some of the data presented were in alignment with the Monitoring Team's metrics/indicators and findings. The Facility's data indicated the following: none of eight (0%) ISP meetings observed had all appropriate disciplines present; seven of eight (88%) ISP meetings had the individual present; eight of eight (100%) ISP meetings consistently used the risk guidelines when determining risk with appropriate justification; four of eight (50%) ISP meetings consistently used supporting individual-specific clinical data when determining risk level; five of eight (63%) ISP meetings designated appropriate risk levels for each category; none of eight (0%) ISP meetings had appropriate clinical discussion among appropriate team members regarding risk levels (all disciplines participated meaningfully by expertise); and two of eight (25%) ISP meetings had participation by the guardians. The Facility's Self-Assessment indicted that based on the findings of the self-assessment, this provision was not in substantial compliance since major systems changes made during the previous review were originally implemented for only two pilot teams in June 2012. In November 2012, the At Risk process was again revised and then implemented facility-wide. In addition, the newly revised statewide forms as noted above were implemented on 1/25/13. The Facility indicated that at the time of the current review, since an insufficient amount of time has passed since the revised forms were implemented, an adequate analysis of the new process could not be conducted. From the significantly problematic findings noted below for Section I, the numerous changes to the At-Risk system had resulted in fragmented documentation that made it difficult, if not impossible to sequentially follow the assessment and action plan processes for a sample of 22 individuals discussed with regard to Sections I.2, and I.3, who the Facility determined to be at high risk regarding health and/or mental health issues. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation	

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		addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process. To assess the Facility's revised risk screening process, members of the Monitoring Team observed four individuals' ISPs meetings (i.e., Individual #184, Individual #91, Individual #268, and Individual #324) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at three (75%) of the observed ISPs. The ISP for Individual #184 did not have the Physician, Home Supervisor, Dietician, and Psychiatry Department representative present. The ISP Preparation Meeting documentation indicated that the physician and Home Supervisor were required at the meeting. Psychiatry was not required, but the justification was inadequate. It stated: "Psychologist will be attending." It should not be assumed the psychologist can represent psychiatry, and further individualized justification should have been provided. The team did not identify the Dietician as a required member of the team. However, given the individual's new diagnosis of osteoporosis, it was unclear how the team concluded that the "assessment is sufficient." ▪ The staff present at the ISP meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all (100%) of the ISPs. ▪ The individual was present at all (100%) of the ISPs meetings observed. Although Individual #184 and Individual #268 left the meetings as needed. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at three (75%) of the ISP meetings. The IDT for Individual #91 did not appear to consistently use the Risk Level Guidelines to determine risk levels since some of the risk levels assigned were not in alignment with the Guidelines without justification provided by the team. ▪ The IDT consistently used supporting clinical data when determining risks levels for one of the ISPs observed (25%). The IDTs for Individual #184, Individual #91, and Individual #268 did not consistently use supporting clinical data when determining risk levels. ▪ Overall, the risk levels the IDT designated were appropriate for each category for one of the ISPs observed (25%) from information and data provided by the IDTs. The individuals' IDTs that did not consistently designate appropriate risk levels for each risk category included Individual #184, Individual #91, and Individual #268.	

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		▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in one (25%) of the ISPs meetings observed. The individuals' IDTs that did not have adequate and appropriate clinical discussion among team members included Individual #184, Individual #91, and Individual #268. ▪ Team disagreements regarding risk levels were noted in one of the ISP meetings for Individual #324 and were resolved based on the use of specific clinical data, the use of the Risk Guidelines, and clinical judgment. ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in all (100%) of the ISPs meetings observed. In addition, other positive observations from the Monitoring Team included: ▪ The team talked about a number of action plans to reduce Individual #184's risks. Some of these were preventative in nature, such as creatively trying to put incentives in place to have him comply with his walking program to reduce his risks for constipation and osteoporosis. Individual #184 had a program to walk four times a week, but he frequently refused. The team tried to develop some person-centered approaches such as moving the time of the implementation of the program to better fit his preferences, and built in tangible incentives. Similarly, Individual #184's team discussed person-centered ideas about ways to have him comply with wearing his helmet to reduce his risks for injuries related to falls. ▪ A member of Individual #184's family was present at his ISP meeting, and when she questioned a significant historical diagnosis, the team discussed a plan for investigating the origin of the diagnosis' inclusion in his medical record. ▪ There was good cross-discipline discussion and problem-solving noted by the IDT for Individual #324. In addition, the team was willing to abandon previous skill acquisition programs (SAPs) that were found not to be working. During discussions, the QDDP kept the team focused on the individual's preferences wherever possible. From observations, all aspects of the ISP planning guidelines were followed and there appeared to be good preparation of materials and information ahead of time. ▪ During some of the team's discussions for Individual #91, a number of the team members remained cognizant of the individual's preferences. ▪ Some of the team members for Individual #268 generated good discussions regarding some of the SAPs based on the individual's personality, history, and clinical needs. In addition, the guardian for Individual #268 was able to take part in the ISP via conference call.	

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		Problematic areas needing focus or improvement included: ▪ The team for Individual #91 did not discuss triggers for any of the risk categories that were rated medium and/or high. In addition, they did not consistently present clinical data to support the rationale for a risk rating, and in many cases, the team's rationales were simply a re-statement of indicators on Risk Guidelines. Also, the team did not adequately discuss the current status of supports and/or present data to indicate if the individual was stable and/or not stable. For example, under respiratory compromise, the IRRF stated: "supports in place have been effective." However, the specific supports were not defined. ▪ The IRRF for Individual #91 stated: "follow nursing protocol: constipation." However, the data presented was incomplete as "record has been thinned out so data is incomplete." In addition, the IRRF regarding Gastrointestinal issues stated that direct support professional staff and nursing staff would monitor for signs and symptoms such as persistent vomiting, unexplained weight loss, gagging, irritability, insomnia, chronic cough, and regurgitation that can be related to GERD, and report them to nursing who would report them to the PCP. However, these triggers/indicators were not present on the individual's PNMP. ▪ The team referred Individual #91 to the PNMT as a result of a questionable 31.4-pound weight gain. This referral to the PNMT did not appear to be appropriate, because the team had not recommended and/or completed an analysis to determine if his reported weight gain was actually accurate. ▪ The physician stated Individual #91's preventative health care "seems to be up to date." However, no data was presented to substantiate that all preventative health care had been completed within the past year. ▪ The IRRF for Individual #91 regarding fluid imbalance indicated that: "he has physician orders to give at least 1000 mls [milliliters] of fluids throughout the day between meals." However, no information was reported if the prescribed fluids were being administered. Also, the order for fluids was not included on the PNMP/dining plan. ▪ Although the team for Individual #184 talked about a fair amount of clinical data, some data was missing, and other data held little meaning, because there was no comparison or analysis of the data in relation to previous data. For example, Individual #184 had a vagal nerve stimulator (VNS), but in the team's discussion about seizures, there was no reference to how often it had been activated. In discussing his risk for cardiac disease, it was noted he had a diagnosis of dyslipidemia and was prescribed medication. Although the most recent lipid panel showed "all values were in the referenced range," no comparison was provided with past levels. Similarly, rather vague data was provided regarding his target behaviors (i.e., they "fluctuate between 0 and 4 episodes per month, averaging 2 episodes per month), and no meaningful comparison of previous data was provided. Rather, the IRRF indicated: "There is	

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		aslight [sic] downward trend observed in the data and some progress has been made." ▪ Specific values generally were not included in the IRRF for labs. At times, this made it difficult to determine if current supports were adequate. For example, Individual #184 had a new diagnosis of osteoporosis with a T-score of negative 2.7. As a result, his risk level went from "low" the previous year to "high." Although the medications and supplements prescribed were listed on the IRFF, no levels for calcium or Vitamin D were provided. In addition, the PCP was not present, and the team did not discuss the appropriateness of the current treatment. ▪ For Individual #184, although action plans were discussed, drafts of action plans were not available for the team's review, and the team did not consistently discuss specific measurable action plans and/or clinical indicators. For example, the team did not develop any specific objectives in relation to his Integrated Health Care Plans to assist the team in determining whether he was remaining stable, or doing better or worse. Nebulous terms such as "encourage fluids" also were used when the team discussed action plans. ▪ The IRRF for Individual #268 did not include specific clinical data in a number of risk areas making it difficult for the team to accurately evaluate the level of the risk. For example, regarding behavioral health, there were no specific target behaviors listed and only a statement that "the data has a downward trend for target behaviors, the replacement behavior is variable." In addition, there was a significant lack of clinical data found under seizures and skin integrity, and no data from the previous year in order to determine if these health issues had improved or gotten worse over the past year. ▪ In spite of several concerns voiced by the guardian for Individual #268 regarding the current medication regimen and findings from the Neurology consults, the physician for the individual did not provide any information to the guardian. Although the nurse on the team provided some information to the guardian, some of the information that she did provide regarding Diastat and laboratory tests was inaccurate. Consequently, many of the concerns of the guardian were not adequately addressed. ▪ When discussing the progress of the SAPs for Individual #268, no actual data was presented to accurately determine how the individual was progressing. ▪ Nursing was not using the nursing protocols when discussing needed interventions and assessments for the high and medium health issues for Individual #268. From the Monitoring Team's observations and record reviews, there had been some positive steps noted regarding the structure and format of the ISP meetings. However, more efforts are needed to ensure that the risk levels are accurate, that the IHCPs reflect	

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		the needed clinical intensity in alignment with the appropriate designated risk levels, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the integrated health care plans, and teams clearly document this process. In addition, CCSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process. The Facility remained out of compliance with this provision.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The Facility's Self-Assessment for this provision indicated the following: ▪ A review was conducted regarding the Integrated Risk Rating Forms and the Integrated Health Care Plans completed from 5/1/12 through 1/31/13 to determine if the IDTs started the assessment process as soon as possible but within five working days, if individuals were re-assessed within five working days in response to changes in an at-risk individual's condition, and if there was a tracking system to ensure completion of the assessments. In addition, the Facility indicated that a review of the Integrated Health Care Plans was conducted to determine if the plans contained consistent risk levels between the IRRFs and IHCPs, specific clinical indicators, implementation dates, the person responsible for implementation, the monitoring frequency, the location of documentation, the person responsible for review of progress/efficacy, completion dates, recommendations for further assessment if necessary as well as a number of additional indicators. Some of the data presented in the Facility's Self-Assessment looked promising regarding the explanations of how samples were selected as well as some of the Facility's findings that were similar to the Monitoring Team's findings regarding items such as the establishment of appropriate plans within 14 days of the plans finalization [0 of 4 (0%)]. However, from discussions with the CNE and Habilitation Therapies Director, the Facility recognized that the quality of the assessments and planning efforts was not being adequately audited, and that some of the clinical disciplines would have to participate in the auditing process in order to address this issue. Based on a review of records for 22 individuals determined to be at risk (i.e., Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals. Problematic issues that resulted in noncompliance included:	Noncompliance

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		▪ Integrated Risk Rating forms did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators. As a result, it was unclear whether further assessment was needed; ▪ There were inconsistencies found between the risk levels on the individuals' Integrated Risk Rating forms, Comprehensive Nursing Assessments, ISPs, and the CCSSLC's At-Risk Individuals list. Reconciliation of these differences was not found; ▪ Due to the lack of documented dates on the various forms, the Monitoring Team was unable to consistently determine what new information was added to a revised Integrated Risk Rating form, and what additional assessments were needed and/or conducted in response to the revised information or possible change of status; and ▪ When recommendations for further assessment were found on the Risk Action Plans/IHCPs, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was actually timely completed. <u>Nursing Assessments</u> Based on a review of 22 individuals' records for which assessments were to be completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues. More specific details are provided with regard to Section M.2. In addition, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 22 individuals found that none of them (0%) contained an adequate assessments of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. As noted in previous reports, nursing had no specific procedure in place addressing the process regarding the nursing assessments and the	

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		analysis of the identified risk indicators. From a review of these nursing assessments, it was clear that some of the Case Managers completing the Comprehensive Nursing Assessments were using past quarterly or annual information without providing any type of update and analysis regarding the current status of the health risk indicators. As noted based on past reviews, the nursing assessments for the At-Risk individuals were not adequate in addressing the health risks of the individuals reviewed. In addition, regarding the Integrated Risk Rating forms, a review of these 22 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that was assigned. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Medical Assessments</u> The 19 active medical record reviews (i.e., Individual #297, Individual #278, Individual #244, Individual #340, Individual #273, Individual #159, Individual #65, Individual #70, Individual #266, Individual #158, Individual #46, Individual #319, Individual #128, Individual #181, Individual #111, Individual #350, Individual #269, Individual #193, and Individual #332) included assessment of the pre-ISPs, IRRFs, the ISP and subsequent ISPAs, and the IHCPs. It was noted that the IRRFs and IHCPs are providing some important documentation including prior assessments and results of the assessments. For the current ISPs and IHCPs, there appeared to be an accurate compilation of tests, procedures and assessments that had been completed for the risk identified. This is an advance from the past, in which IDTs did not have knowledge of tests and test results already completed. However, as mentioned in the following examples, there appeared to be difficulty in documenting timeliness of response, as well as responding in a timely manner to ongoing concerns. There appeared to be additional need for the IDT to understand the need to review steps to be taken to prevent a repeat hospitalization or changes in health status. Timely response of the IDTs to the need for an assessment remained a challenge. The structure of the documentation process did not clearly identify the initial date of the assessment process. In many cases, the IDT met after an individual returned from the hospital, rather than initiating meetings within five days of the onset of the change in health. This would have allowed time for a record review or discussion of areas of	

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		concern noticed by the IDT members when details could be recalled accurately. The following represents a case in which there had been ongoing problems, but this did not appear to be addressed until the individual was hospitalized. ▪ The IHCP of 11/2/12 for Individual #350 indicated that he required 15 bowel interventions in the prior year (including 13 enemas). He received Milk of Magnesia (MOM), Bisacodyl suppositories, and Colace liquid daily. More recently, he received as needed (PRN) constipation medications on 7/24/12, 8/10/12, 8/19/12, 8/29/12, 10/14/12, and 11/1/12. There was mention of Fiberstat in the Action Plan of the IHCP, but the Monitoring Team could not find an order for Fiberstat dating from 11/2/12 or proximal to that date. On 11/13/12 to 11/19/12, he was hospitalized for rectal bleeding, and required a blood transfusion. Diagnostic evaluation in the hospital did not find the source of the blood loss. When the individual returned to CCSSLC, he was additionally given Fiberstat, ordered 11/21/12, as well as twice daily prune juice. The IDT did not appear to aggressively treat his constipation to minimize PRN usage of enemas and other medication. Allowing the individual to become repeatedly constipated provided poor quality of life. It was temporally associated with his rectal bleeding and hospitalization. It was not clear at what point the IDT would convene to discuss the monitoring and treatment of his constipation. Medication was not added until after the hospitalization. Additionally, this individual had weekly weights, but an ISPA of 12/18/12 indicated that his weights were stable, and the team discontinued the weekly weights. There was no information indicating the weights and dates of the weights that were the basis of the team decision. It is recommended that data important to the IDT decision process be included in the ISPA. There were several other records reviewed that indicated a delay in IDT follow-up, based on the documents submitted. In other instances, the IDT did not appear to be aware of changes in health and the implications of this. ▪ On 9/12/12, Individual #158 sustained a fracture of his leg. This required a cast, and use of a wheelchair. The fracture was the result of aggressive behavior. There was no ISPA submitted for this to discuss prevention of another aggressive behavior and fracture. The 11/6/12 ISP and IRRF documented this finding. There did not appear to be a timely response by the IDT, or the ISPA was not submitted. ▪ From 10/2/12 to 10/9/12, Individual #340 was hospitalized, then returned to the Infirmary, and was discharged to his home on 10/17/12. He had a partial small bowel obstruction that responded to	

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		conservative treatment. He also had pneumonia and possibly a UTI. The ISPA of 10/17/12 reflected an Infirmary team meeting, although this document was not submitted. When in the Infirmary, he developed a decubitus on his buttock. He had dislodged his feeding tube twice, and an abdominal binder was placed to prevent recurrence. The ISPA mentioned continuation of the PNMP for positioning, but did not mention how the positioning plan was to be adapted to assist in his decubitus healing, or if it was a written positioning plan. This individual was hospitalized other times in the past year, including 10/29/12 to 11/5/12 for an upper GI bleed, and was discharged from the Infirmary on 11/12/12, and hospitalized 12/6/12 to 12/19/12 for pneumonia, and was discharged from the Infirmary on 1/14/13. The ISPAs did not provide guidance to the direct support professionals and other IDT members in the post-hospital care. This information might have been located in other documents, but it did not appear to be summarized or referenced. ▪ From 8/31/12 through 9/2/12, Individual #159 was hospitalized for a fecal impaction. She had been on Miralax and Unifiber, and on 9/6/12, prune juice and Fiberstat were added. The actual regimen for constipation was difficult to track as some of the orders were included in a "Diet Request" sheet separate from the physician orders. It appeared the IDT met in a timely manner. However, not responding to constipation until an impaction occurs that requires hospitalization indicated the need for in-service training, and improved monitoring of this condition. The IDT did not appear to respond in a timely manner in resolving/preventing her constipation. Additionally, despite being on one-to-one supervision, her pica habit remained challenging. The ISPA addendum of 3/11/13 indicated that there was discussion of "pica – transfer to another facility which provides adequate environment for pica clients." There did not appear to be a discussion of obtaining an outside consultant for her pica behavior, or determining the reason for pica when she was on one-to-one supervision (e.g., individual left alone, staff needing further training, distractions, etc.), and the need for additional staff support, etc. Without additional steps, she remained at risk for further pica. ▪ There were several individuals admitted to the hospital, for which the ISPA appeared informational, but did not reflect critical discussion of steps to prevent a recurrence. Individual #128 was admitted to the Infirmary from 12/3/12 through 12/17/12 for pneumonia and wheezing, but the 12/17/12 ISPA did not address preventive steps. ▪ From 12/5/12 through 12/21/12, Individual #278 was hospitalized for	

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		pneumonia, but an ISP of 12/21/12 did not list preventive steps to be taken or review of the pre-hospital clinical course. ▪ Individual #273 was hospitalized three times in 2012 with respiratory issues, including desaturation, but the ISPAs did not discuss early signs and symptoms of illness in the individual or address steps to prevent acute illness. Overall, the ISPAs did not appear to address critical preventive steps. IDTs should demonstrate timely meetings, and not wait until the individual is discharged from the Infirmary before documenting action steps. The initiation of the assessment compared to the onset of change of status was not clear in most cases. Medical providers needed to take a lead role in working with teams to make sure proper assessments and interventions were identified and implemented. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	Based on a review of 22 records for individuals determined to be at risk (i.e., Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this	Noncompliance

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		indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 20 of the cases (91%). Individuals who had not had their IHCPs/Risk Action Plans integrated into their written ISPs included: Individual #224, and Individual #297. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. The examples that follow focus on the concerns of care in the residence, especially the lack of supervision and the quality of nursing care. ▪ Individual #46 had a choking episode when the individual attempted to swallow an entire chicken breast whole. This led to partial airway obstruction, hospitalization, and ventilator support. During his two-week hospital stay, the chicken was found lodged in his esophagus and was pushed through to the stomach. He recovered. A follow-up swallow study indicated no problems, and he continued to eat a regular diet. He had several events approximately four months later. He tried to eat chicken along with the chicken bone, and the IDT determined the kitchen would debone the chicken prior to serving it. A PNMT note documented he refused to cut the chicken prior to eating. It was reported he ordered pizza by himself, without staff support, then ate it. He had clearly demonstrated he was at-risk due to being an unsafe eater. For a short time after the choking incident he was on one-to-one staffing during meals, but that was discontinued. However, the team believed increased supervision would escalate behavior and the Psychologist indicated that one-to-one supervision at all times was not justified. As of October 2012, he was placed on routine supervision at all times. A PBSP was in place for several triggers. That he is sufficiently independent to order pizza makes this a challenging situation, along with the behavioral issues. However, when focusing on the risk of choking, he had a severe choking episode requiring two weeks of hospitalization. One ISPA did indicate he was improving with chopping his food. However, he remained unsupervised. That was on routine supervision during	

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		mealtimes would not appear to provide the safety needed. Not all documents were available, but there was no information concerning whether he would benefit from a smaller snack between meals, whether his unsafe and rapid eating had predictors, and whether the housemates made his risk worse. However, it appeared his risk remained high, and there were no current steps to monitor him closely during meals or other actions to reduce his risk, despite his life-threatening event this past year. ▪ Individual #128 developed pneumonia and wheezing and was treated in the Infirmary. Approximately three weeks later, the individual developed hypothermia when a nearby window was left open. The ISPA indicated staff were trained on ensuring the window was closed. However, there appeared to be no action steps related to monitoring to ensure the window was closed. Alternative actions such as moving the bed away from the window would have provided additional safety. ▪ Individual #297 had an order to receive nothing by mouth, but swallowed chicken with bones, drank coffee, and swallowed an egg at different times within one week. No ISPA was submitted during that week or the following to indicate the team reviewed these concerns and made further action plans to reduce these high-risk behaviors. ▪ As discussed with regard to Section G.1, Individual #127, in which a post hospitalization was followed by an active record review, the lack of nursing care plan development and training of the direct support staff was problematic. ▪ As discussed with regard to Section L.1, it was a systemic concern that only four of 19 (21%) active problem lists were up-to-date with significant diagnoses. These diagnoses were then discussed at the ISP and included in the ISP with development of action steps. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this area. This finding was consistent with the findings of the Monitoring Team. CCSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate IHCPs. These plans should meet the individuals' needs, contain functional, and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

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

1. In prioritizing involvement in the ISP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. (Section I.1)
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry

concerning results. The IDTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)

3. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the PSTs. Currently, the description of high risk for infection requires two or more Multiple drug resistant organism (MDRO) infections, or an open wound. It would be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound. (Section I.1)
4. Additional training on the at-risk process should be provided to the IDTs. This is necessary to ensure that the at-risk process adequately identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified. (Sections I.1, I.2, and I.3)
5. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. (Section I.1)
6. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
7. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
8. When there is a change in health status, the IDT should reconvene to rate the categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan. Particularly, when an individual is hospitalized and subsequently discharged home, the IDT should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)
9. It is important to create a standardized approach to differentiate the original plan/information from updates and other information that is entered into the plan, with dates of each additional entry. (Sections I.1, I.2, and I.3)
10. The Facility should create a tracking system listing dates of action that follow the identification of individuals at risk, including the assessment process and the development and implementation of risk action plans. (Sections I.2 and I.3)
11. The areas that the At-Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.2)
12. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
13. Given that IDTs, at times, do not realize when more assessment is indicated, department heads should review IDT findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Sections I.1, and I.2)
14. A summary list of the assessment(s) being requested as a result of the IRRF or ISPA should be created to assist in tracking the completion of the assessment. To use this as a tracking tool, it would be helpful if it included the date of request, date completed, date received by the IDT, date discussed at an IDT meeting, and date of ISPA at which it was discussed and acted upon, if applicable. (Section I.2)
15. The Facility should decide upon a system for quarterly/monthly updates, including whether these should be maintained in the documents themselves, or in a separate document. (Section I.3)
16. The ISP and related action plans should capture the interdisciplinary discussion about the risks defined for the individual. (Section I.3)
17. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it. (Section I.3)
18. The Facility should monitor the ISPs to ensure the risk ratings and action plans are integrated into individuals' ISPs. (Sections I.1, I.2, and I.3)
19. Regarding the Facility's self-assessment system addressing Section I, the Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. (Facility Self-Assessment)
20. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation, using, for example, tables to report monitoring findings rather than a narrative format that is more appropriately used to summarize the analysis of the data.

(Facility Self-Assessment)

21. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Self-Assessment to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. (Facility Self-Assessment)

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; 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; o Job Descriptions of Psychiatrists; o List of individuals whose psychiatric diagnoses have been revised, along with the Psychiatrist's rationale for the new diagnosis; o List of individuals prescribed intra-class polypharmacy, with total number of medications prescribed; o List of all meetings and rounds that the Psychiatrists typically attend, including other professional disciplines that usually attend those meetings; o List of support services for Psychiatry Department; o Minutes of Polypharmacy Meeting Review for the last six months; o In response to Monitoring Team's request for documentation pertaining to complaints about the psychiatric and medical care at CCSSLC, documents indicating no complaints; o Lists of individuals with tardive dyskinesia, and individuals being monitored for tardive dyskinesia; o List of all individuals prescribed psychotropic medication, including diagnosis, name of medication, and dosage; o List of all individuals prescribed anticonvulsant medication as a psychotropic medication; o List of individuals who were psychiatrically hospitalized within the prior six months; o List of Individual Support Plan Meetings attended by members of the Psychiatry Department within the prior six months; o Consent database for psychotropic medication; o Examples of the medication side effects monographs for five psychotropic medications; o Psychiatric symptoms tracking scale definitions, updated 6/29/12; o Chemical restraint trending data for the last six months, and the chemical restraint administration documentation for the last six months; o Comprehensive Psychiatric Evaluation (CPE) completion status spreadsheet and ten examples of recently completed CPEs; o Spreadsheet listing the individuals who are followed in the Neurology Clinic with notations as to which individuals are also followed by Psychiatry and the date of recent visit to Neurology Clinic; o Neurology Clinic notes and the corresponding Quarterly Psychiatric Clinic notes for the following individuals and the (date of Neurology Consultation): Individual #26 (2/2/13), Individual #184 (2/2/13), Individual #297 (2/2/13), Individual #55 (2/2/13), Individual #153 (2/2/13), Individual #60 (2/2/13), Individual #136 (3/3/13), and Individual #141

	(2/2/13); o Spreadsheet of Reiss Screen Examinations for all CCSSLC individuals, and the CPEs for those individuals that had an elevated score and were not followed in the Psychiatric Clinics; o List of individuals receiving anticholinergic medication; o List of individuals prescribed benzodiazepines; o The sections from the active record as follows: Face Sheet, Social History, Rights Assessment, Consents for Psychotropic Medication, Consents for Pre-Treatment Sedation Medication, Human Rights Committee (HRC) section and Referral Form, as well as Addendums related to Psychotropic Medication, the Individual Support Plan (ISP) and Addendums, Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section, for the following individuals: • The Facility selected the following individuals for the pre-review document request: Individual #47, Individual #295, Individual #13, Individual #237, Individual #354, Individual #72, Individual #136, Individual #359, Individual #283, and Individual #34; and • The following individuals were selected based on the acuity of their psychiatric presentation: Individual #53, Individual #95, Individual #318, Individual #172, Individual #61, Individual #238, Individual #40, and Individual #218; o The master spreadsheet for completion of the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) for the last six months; o List of individuals receiving Reglan as of 4/1/13, and who were not prescribed psychotropic medication; o Curriculum Vitae (CV) and Contracts for the following: Dr. Babu Draksharam, locum tenens Psychiatrist; Dr. Gollavelli Krishna, Director of Psychiatry Services; and, Dr. Michael Hernandez, Consulting Psychiatrist; o MOSES and DISCUS side effect rating scores for the last year for the following individuals receiving Reglan who were not also receiving a psychotropic medication: Individual #137, Individual #270, Individual #205, and Individual #113; o CCSSLC Presentation Book for Section J - Psychiatric Services, which contained the following sections: a) Compliance Review; b) Plan of Improvement; c) Monitoring Tools; d) Evidence J.1 through J.15; and e) Recommendations 1 through 3 and Recommendations 7 through 10; o Restraint documentation related to the administration of the following six incidents of chemical restraint and the (date): Individual #238 (1/30/13), Individual #40 (1/27/13), Individual #144 (1/24/13), Individual #238 (1/24/13), and Individual #238 (1/24/13); o Material presented and discussed at the 4/3/13 Pharmacy and Therapeutics Committee Meeting; o The clinical documentation related to the 4/2/13 Psychiatric Clinics; o Data related to the Quality Assurance Department's ongoing assessment of the Psychiatry Department's progress in meeting the requirements of the Settlement Agreement;

	o List of admissions to CCSSLC within the last year, inclusive of the date of admission; o List of ISP Meetings attended by a member of the Psychiatry Department within the last 12 months, including date of the ISP Meeting and the member of the Psychiatry staff that attended the meeting; o The analysis of the allocation of time commitments of the Psychiatrists who work at CCSSLC; o Psychiatric Symptoms and Target Behaviors Flow Sheet; o Chemical Restraint Trending Data for the last year; o Minutes/documentation related to the Desensitization Committee Meetings for the last six months; o The decision-tree for the dental desensitization assessment to be used by the Dental Clinic personnel; o Spreadsheet listing individuals deemed to not be appropriate for a Desensitization Plan; o Documentation of the training that Nursing staff received with regard to completing the DISCUS evaluations; o Consent packets for psychotropic medications for the individuals reviewed during the 4/3/13 meeting of the Human Rights Committee; and o Consent Tracking database/spreadsheet the Psychiatry Department maintains. ▪ **Interviews with:** o Glynn Bogard, Psychiatric Assistant; Michelle P. Lora-Arteaga, R.N. and Lindsay Hertz, R.N., Psychiatric Nurses; and Joseph Ward, Psychiatric Assistant, on 4/4/13; o Michael Hernandez, M.D., Consulting Psychiatrist, on 4/2/13; o Judy Sutton, MS, BCBA, Director of Behavioral Services, on 4/1/13; o Janet Way, Pharm.D., on 4/1/13 and 4/4/13; o Enrique Venegas, D.D.S.; and Kathy Roach, Dental Hygienist, on 4/1/13; o Karen Forrester, Human Rights Officer, on 4/3/13; o Glynn Bogard, Psychiatric Assistant; on 4/1/13, 4/2, 4/3/13, and 4/4/13; o Glynn Bogard, Psychiatric Assistant, and Araceli Matehuala, Program Compliance Monitor for Psychiatry to review Facility Self-Assessment, on 4/4/13; o Gollavelli Krishna, M.D., on 4/2/13; and o Babu Draksharam, M.D., on 4/2/13. ▪ **Observations of:** o Psychiatric Clinics, on 4/2/13; o HRC Meeting, on 4/3/13; o Medical Morning Meeting, on 4/3/13; o Pharmacy and Therapeutics Committee Meeting, on 4/3/13; o The following individuals were observed during the onsite review of the residences and program sites: Individual #238, Individual #191, Individual #90, Individual #318, Individual #44, Individual #172, Individual #12, Individual #253, Individual #251, Individual #157, Individual #237, Individual #367, Individual #353, Individual #348, Individual #167, Individual #144, Individual #323, Individual #297, Individual #218, Individual #332, Individual #138, Individual #95, Individual #132, Individual #92,

	Individual #296, Individual #184, Individual #47, Individual #300, Individual #177, Individual #308, Individual #115, Individual #298, Individual #242, Individual #158, Individual #311, and Individual #83.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, which was prepared on 3/18/13. In its Self-Assessment for each sub-section, the Facility identified: 1) activities used to conduct the Self-Assessment; 2) the results of the Self-Assessment; and 3) a self-rating. For Section J, in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the audit template guidelines, a sample of completed monitoring tools, inter-rater reliability data, as well as interviews with the Program Compliance Monitor for Psychiatry, and the lead Psychiatric Assistant, a member of the Monitoring Team made the following observations: o The audit tool for Section J was developed within the Facility, but was derived from the audit tool DADS State Office developed. The other methodology the Facility utilized was longitudinal spreadsheets/databases that were continuously updated. The specific application of these methods is described below. o These monitoring tools included indicators to allow the Facility to determine compliance with the Settlement Agreement, if they were consistently applied to a large enough sample with adequate determination of inter-rater reliability between multiple raters. o The monitoring tools consisted of methodologies that included an analysis of cross-sectional data that utilized sample sizes ranging from eight percent to 26 percent of the individuals prescribed psychotropic medication as described below. The other methodology utilized consisted of databases to monitor the Psychiatry Department's progress toward completing specific evaluations for all individuals prescribed psychotropic medication. o The Self-Assessment identified the sample(s) sizes, including the number of individual records reviewed in comparison with the number of individual records in the overall population. This sample size was adequate to consider them representative samples for some, but not all of the provisions in Section J. o The PCM and a Psychiatric Assistant each reviewed one individual record a month as separate reviewers who were blind to each other's ratings. The data derived from this process was used to establish inter-rater reliability. A formal statistical assessment of inter-rater reliability was not performed, but the simple percentage congruence ratings ranged from 50 percent to 100 percent. The lead Psychiatric Assistant subsequently performed sample-based, cross-sectional analyses for specific provisions. Only this individual completed these reviews. The smaller samples, which had previously been completed by both the PCM and lead Psychiatric Assistant to assess inter-rater reliability, were omitted from the Facility Self-Assessment. When the cross-sectional analyses were carried out, there were 117 individuals who were prescribed psychotropic medication. The size of the cross-sectional samples, for the sections in which this methodology was used as the primary way of assessing compliance rates, were as follows:

J.3 21 of 117 – 18 percent
J.4 12 of 81 (individuals receiving pre-treatment sedation) – 15 percent
J.8 31 of 117 – 26 percent
J.9 16 of 117 – 14 percent
J.12 nine of 117 – eight percent
J.13 22 of 117 – 19 percent
J.15 15 of 72 (individuals followed by the Psychiatry and Neurology Departments) – 21 percent

a. The monitoring tools had adequate guidelines to ensure consistency in monitoring the results, as they were directly derived from the language of the Settlement Agreement. However, they did not include specific instructions to determine the validity of the methods, such as the required sample size and the necessary degree of inter-rater reliability.
b. The following staff members were responsible for completing the audit tools: The PCM assigned to the Psychiatry Department and the Section lead Psychiatric Assistant for Psychiatry. However, as noted above, the reviews performed by the PCM and lead Psychiatric Assistant, were only used to assess inter-rater reliability. The cross-sectional analyses referred to above were performed only by the lead Psychiatric Assistant. The longitudinal databases used for some sections were a joint effort between the Psychiatric Nurses, and the two Psychiatric Assistants.
c. The staff members responsible for conducting the audits were working to ensure there was clinical competence in the area(s) of the auditing process for which they were responsible. However the Facility did not have a separate process for assessing the competency of the individuals to complete these audits in a reliable manner. The PCM attended some Polypharmacy Meetings and had, on occasion, attended a Psychiatric Clinic to become more knowledgeable about the clinical issues. This staff did not score items that would require clinical expertise to make an assessment of quality, but did score for the presence or absence of items. For example, the PCM would score on the consistency of the psychiatric diagnosis between different sections of the record, but would not comment on the validity of that diagnosis. The lead Psychiatric Assistant had several years of experience, as well as a doctorate degree in a related field and was qualified to make decisions about the quality of the products reviewed.

- Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. As indicated above, the Facility was not suggesting that the current scores were sufficient to make a valid determination of inter-rater reliability.
- In addition to the cross-sectional samples, the Facility used other relevant data sources. Specifically, the Psychiatry Department maintained detailed databases related to specific documents, such as the CPEs and the diagnostic checklists that were used to establish the psychiatric diagnosis (Section J.2, Section J.6, and Section J.13), the polypharmacy statistics (Section J.11), the MOSES/DISCUS monitoring (Section J.12), and the Reiss Screening

evaluations (Section J.7). They were able to utilize this information to document completion rates for the entire population of individuals receiving psychotropic medication.

- The Facility generally presented data in a useful way. Specifically, their use of longitudinal databases, which reported the completion rates for items such as the MOSES/DISCUS administration, the CPE completion statistics, and the administration of the Reiss Screening instrument, produced a simple, straightforward means of assessing progress. The reports of the cross-sectional samples referenced above were also straightforward. However, the fact that only one rater completed these was not clearly stated, and the data related to inter-rater reliability was omitted.
- The Facility organized their self-assessment around specific indicators derived from the Settlement Agreement and the Monitoring Team's prior reports.
- The Facility rated itself as being in compliance with the following sub-sections of Section J: Section J.1, Section J.2, Section J.7, Section J.11, Section J.14, and Section J.15: This was not consistent with the findings of the Monitoring Team. The comparison of the Facility's ratings and those of the Monitoring Team for these provisions is as follows:

Section	CCSSLC	Monitoring Team
J.1	SC	SC
J.2	SC	SC
J.7	SC	SC
J.11	SC	NC
J.14	SC	NC
J.15	SC	NC

The discrepancy between the ratings for J.14 was primarily derived from the deficient risk assessment upon which the consents were based. The divergence in the ratings for J.15 was related to the decline in the frequency with which the Neurology Consultation Notes mentioned the individual's psychiatric treatment. There was also a discrepancy between the Facility's finding of noncompliance for Section J.5, whereas the Monitoring Team found substantial compliance. The explanation for this difference appears to be related to the fact that the Facility's self-assessment was prepared prior to the Facility's acquisition of the two full-time Psychiatrists described in the narrative discussion of Section J.1 in the Monitoring Report.

- The Facility data identified areas for improvement. The Facility Self-Assessment provided some limited analysis of the information. This identified some potential causes for the issues, but did not perform a detailed, root-cause analysis. In addition, the Self-Assessment did not connect the findings to the Facility's Action Plans to illustrate what actions the Facility had taken or was planning to take to address the deficiencies.

Summary of Monitor's Assessment: The positive changes that had occurred since the prior review

	included the addition of two full-time Psychiatrists, one of who was serving as Director of Psychiatric Services. The other, who was at the Facility on a long-term locum tenens basis, was continuing to maintain the CPEs on an ongoing basis. The Consulting Psychiatrist continued to work at the Facility for eight hours each week, and the two Psychiatric Nurses and the Psychiatric Assistants continued to support the Psychiatrists. The Director of Psychiatric Services also planned to assume the direct clinical care of some of the individuals who the Consulting Psychiatrist had followed, but the caseload distribution had yet to be determined. One of the challenges continuing to confront the Psychiatry Department at CCSSLC was the integration of the clinical material, described in Sections J.8, J.9, and J.10, into the ISP documentation. The newly developed Psychiatric Medication Treatment Plan was to be completed with the Integrated Risk Rating Form at the time of the annual ISP meeting. In addition, it was expected that the increase in the number of Psychiatrists would make it possible for a member of the Psychiatry Team to lead the discussion of this material at the individuals' annual ISP meetings. These initiatives might address the requirements to integrate aspects of the individuals' psychiatric treatment into the ISPs. Another major challenge was the continued high rates of polypharmacy. The Psychiatry Department had begun to organize this data on a categorical basis. This effort should enable the Psychiatric Team to both assemble and then effectively present the necessary historical information to justify, as appropriate, the continued use of the medications. CCSSLC had maintained thorough documentation of the symptoms needed to establish the individual's psychiatric diagnosis, as well as the differentiation of those behaviors that derive from the psychiatric diagnosis, as opposed to those that were present on a behavioral basis. The effort to complete the annual updates to the CPEs was negatively impacted by the inability of the Psychiatrist responsible for that process to continue, but had resumed with the new locum tenens Psychiatrist. The addition of two full-time Psychiatrists and the continuation of work by the Consulting Psychiatrist, working in conjunction with the two Psychiatric Nurses and two Psychiatric Assistants, should enable the Psychiatry Department to not only maintain the improvements in psychiatric care it had already achieved, but also to continue making progress in areas requiring improvement.

#	Provision	Assessment of Status	Compliance
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 interviews, which took place during prior reviews, he indicated that, in addition to his consultation at CCSSLC, he 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		community mental health clinic. At the time of the 4/2/13 Psychiatric Clinics, he stated that he continued to treat a significant number of individuals with ID/DD in his private practice and estimated that he had engaged in providing psychiatric services to individuals with ID/DD for over six years. He had been a psychiatric consultant to CCSSLC for approximately six 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. During the time periods both before and following the last review, the Facility had contracted with Dr. Jason Kirkpatrick through a locum tenens physicians' agency. During Dr. Kirkpatrick's tenure at CCSSLC, Dr. Hernandez continued to provide the direct psychiatric services to the individuals receiving psychotropic medication, while Dr. Kirkpatrick focused on completion of the Comprehensive Psychiatric Evaluations (CPEs) for the individuals receiving psychotropic medication. His qualifications were discussed in the Monitoring Team's prior report. Dr. Kirkpatrick was scheduled to return to this Facility in January 2013 to resume his work related to updating the CPEs, but was unable to do so. CCSSLC recently had secured the services of another Psychiatrist through a locum tenens contract. On 1/28/13, Babu Draksharam, M.D. began work at CCSSLC with the commitment to remain through the calendar year, and indicated he was willing to make a longer commitment. The review of his CV, coupled with the 4/2/13 interview, indicated that he graduated from medical school in India. Dr. Draksharam received his post-graduate training in the United States, completing a Residency in Psychiatry at Baylor Medical School. Accordingly, he would be considered Board Eligible in Adult Psychiatry, but he had not taken the examinations required to be Board Certified. He passed the examination of the Educational Commission for Foreign Medical Graduates (ECFMG) in 1976 and had maintained a license to practice medicine in Texas since that time. His professional life primarily involved work within public sector psychiatry, including the correctional system and then the State Mental Health Hospitals. Dr. Draksharam had a private practice from 1991 to 2000. He fully retired from practice during the time period of 2002-2008, and since his return to professional practice, had been doing locum tenens work in Texas. This later work included several months of work at the DADS facilities in Rio Grande and San Antonio, where he worked extensively with individuals with ID/DD. The Facility also had hired Gollavelli Krishna, M.D., who began in mid-March 2013 on a full-time basis, as the Director of Psychiatry Services. She was currently attending the Facility's orientation program. Dr. Krishna attended medical school in India, and obtained her Post-Graduate Training in the United States, completing a Residency in Psychiatry at the Stony Brook Branch of the New York State Medical School system. She qualified for a license to practice medicine in New York, after passing the ECFMG and	

#	Provision	Assessment of Status	Compliance
		Flex Examinations. Her professional work was primarily in the Veterans' Administration Hospital and then the Staten Island Psychiatric Hospital in New York, where she also had administrative responsibilities. Dr. Krishna is Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, and was currently licensed to practice medicine in Texas. Although she had not had extensive, direct clinical experience working with individuals with ID/DD, as noted above, she did have extensive experience with both the clinical and administrative responsibilities regarding public sector psychiatry. The Facility was found to be in substantial compliance with this provision based on the observation that Drs. Hernandez and Krishna were certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. Dr. Draksharam was Board Eligible, having completed a psychiatric residency at a fully accredited training program. In addition, Drs. Hernandez and Draksharam had significant clinical experience with this specific population. While Dr. Krishna did not have this clinical experience, the review of her work within the public sector, as well as her recent Continuing Medical Education activities, indicated that she had a solid grasp of the clinical issues presented by individuals who have both mental illness and ID/DD.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	As noted above, at the time of the review, the primary Psychiatrist who diagnosed and treated the individuals who resided at CCSSLC was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. This Psychiatrist also had extensive prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. The new locum tenens Consulting Psychiatrist, whose sole function was to complete the CPEs, was Board Eligible in Adult Psychiatry, having completed a residency in Adult Psychiatry at an accredited Psychiatry Residency Program. The Director of Psychiatry had not yet begun her clinical work at CCSSLC and, thus, her contribution to the current process of psychiatric diagnosis could not be assessed. The three Psychiatrists' backgrounds are discussed in more detail with regard to Section J.1. Although the psychiatric diagnoses appeared in a number of sections of the individuals' records, the clinical justification that supported the validity of the diagnosis primarily appeared in the related sections of the CPEs and the Quarterly Psychiatry Reviews. The Quarterly Psychiatry Review process and documentation is discussed in detail with regard to Section J.13, as it is more pertinent to that section. As noted in the prior reviews, the Facility had begun an initiative to complete a thorough CPE that would comply with the terms of the Settlement Agreement for all of the individuals who were receiving psychotropic medication. The Facility's status with regard to the CPEs is discussed in detail in Section J.6. The discussion here primarily relates to the results obtained by the comprehensive review of records of 16 percent (n=18) of the 114 individuals prescribed psychotropic medication at the time of the onsite review. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		sample is described in more detail above in the section of this report that details the documents reviewed. The sub-sections of the individual records that were reviewed are also specified. The review of the clinical record of these 18 individuals indicated that there was adequate clinical justification for the diagnosis of record for all of the 18 individuals identified in the sample (100%). This documentation could be found in the sections of the CPE specifically devoted to the psychiatric diagnosis and the related section that discussed the "Bio-Psycho-Social-Spiritual Formulation." The CPEs for 11 of these 18 individuals had not been updated within the prior 12 months. However, the psychiatric diagnosis for these individuals had not changed in this timeframe and, thus, the discussion in the existing CPEs remained relevant. The material in the Quarterly Psychiatric Review documentation that specifically addressed this were the diagnostic sections, which included a listing of the overt symptoms of the disorder that the individual presented with, as well as the "DSM-IV Diagnostic Checklist." The Checklists reproduced the diagnostic criteria for an individual's diagnosis (as listed in the Diagnostic Manual), and then the specific symptoms manifested by the individual were checked off, so that it was easy to determine if the DSM-IV criteria for that diagnosis had been met. In addition, CCSSLC had developed psychiatric symptom tracking scales. These scales provided operational definitions of 21 symptoms common to many of the most prevalent Axis I psychiatric disorders. The IDT members who routinely attended the Psychiatric Clinics, working in conjunction with the Consulting Psychiatrist and the broader psychiatry team, tailored the specific symptoms monitored for each individual. The revised policy related to the psychiatric review, updated on 4/27/12, discussed these checklists under the sub-heading: "Ensuring Clinically Justified Psychiatric Diagnosis." At the time of the prior review, these procedures had been implemented, and the evidence regarding the training the nurses received related to this instrument was described in the previous report. The Unit Nurses monitored the frequency and intensity of these symptoms and the results were presented at the Quarterly Psychiatric Clinics, which were also attended by direct support professionals (DSP) who would also be able to comment on their observations. The raw data for this information was not included in the individual's record, but was commented on in the narrative portion of the Quarterly Psychiatry documentation, which the Consulting Psychiatrist prepared. During the onsite interviews, members of the Psychiatry Team indicated that, although this instrument had served to augment the diagnostic process, they were investigating the use of a published, validated instrument to replace the current 21-symptom checklist. At the time of the Monitoring Team's onsite review, the CCSSLC team had not yet decided on a new instrument.	

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		CCSSLC also maintained data on the number of psychiatric diagnoses that had been modified or changed over the last six months, and this data indicated that there had been 11 diagnostic changes. This material also contained a description of the rationale for those changes, all of which appeared to be reasonable. The review of this information, as well as the clinical material for the sample of 18 individuals, indicated that the Psychiatry Department at CCSSLC did not utilize "NOS" (Not Otherwise Specified) diagnosis, nor did they use "R/O" (Rule Out) qualifiers unless they were indicated for a brief period of time for a newly admitted individual. The review of the spreadsheet that listed the names, psychiatric medications, and psychiatric diagnosis for all of the individuals who were receiving psychotropic medication also confirmed these observations. An issue the Monitoring Team identified in its previous reports with regard to psychiatric diagnoses related to the observation that the identified target behaviors of the psychiatric medications frequently were described in the Psychology section of the record as stemming from learned behavioral and/or an environmental issue. The current review found that this problem had been rectified and did not occur in any of the individual records reviewed. The Facility's improvement in this regard was primarily due to two systematic changes that the Psychiatry Department and Psychology Department had implemented in their respective documentation. These changes also were directly responsive to recommendations made in the Monitoring Team's prior reports. As mentioned above, the Psychiatry Department now identified the symptoms of the psychiatric diagnosis for which the medication was prescribed. The link between the symptoms of the psychiatric disorder and the monitored behaviors also was clarified in both the CPE and the Quarterly Psychiatric Review documentation. For some individuals the actual symptoms of the psychiatric disorder represented the behavior that was monitored. There were also situations in which the monitored behavior was directly derived from the symptoms of the disorder, but was not a direct symptom of the disorder. An example of this would be an individual for whom the incidents of aggression were directly related to auditory hallucinations that were commanding them to hurt someone. The Psychology Department had added a section to their documentation entitled: "Psychiatric Information," which included the psychiatric diagnosis as well as the impact of that psychiatric disorder on the individual's challenging behaviors. Thus, it was possible from these sources to ascertain which behaviors the IDT judged to be related to the symptoms of the psychiatric disorder, as opposed to being present on a purely behavioral basis, or influenced by both biological and behavioral factors. The finding of substantial compliance is based on the consistency with which these	

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		assessments were carried out, the thoroughness of the clinical documentation, and the concordance between the diagnostic material contained in the Quarterly Psychiatric documentation, the CPEs, and the Psychology section of the individual records. As indicated with regard to Section J.6, the annual updating of the CPEs had not yet been completed for 26 percent of the 114 individuals prescribed psychotropic medication. However, the spreadsheet that tracked the completion dates of the CPEs indicated that there had been a prior CPE that met the criteria of the Settlement Agreement, as based on the extensive sample of CPEs that were assessed during the current and prior reviews. Thus, the Bio-Psycho-Social Formulation contained in these documents continued to support the diagnosis contained in the Quarterly Psychiatric Review documentation.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The individual interviews with the Psychiatry Department staff, as well as the review of the records of 18 individuals prescribed psychotropic medication, did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. During the onsite review, a member of the Monitoring Team directly observed approximately 32 percent of the 114 individuals prescribed psychotropic medication. The identifying information for these individuals is listed above in the section entitled: "Observations of." These observations did not identify any individuals who appeared to be grossly over-medicated with psychotropic medication, as might have been expected if these medications were routinely used for the convenience of the staff. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication is discussed with regard to Sections J.2, J.6, and J.13. In addition, the review of the spreadsheet listing all of the individuals' prescribed psychotropic medications indicated that each of these individuals had a psychiatric diagnosis of record. The 18 records reviewed showed an active Positive Behavior Support Plan was present for each individual prescribed psychotropic medication. The quality of the PBSPs is discussed in detail with regard to Section K.9. The Monitoring Team's previous reports had noted a significant concern related to behaviors identified as the "target behaviors" of the psychotropic medication also being identified in the Functional Analysis and related PBSP as being present on a behavioral basis and/or related to environmental factors. This observation suggested that for these individuals, the prescribed psychotropic medication could have been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this provision of the Settlement Agreement. In other words, they potentially were being used in the absence of adequate behavioral treatments or interventions.	Noncompliance

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		At the time of the Monitoring Team's previous review, the Psychiatry Department, working in conjunction with the Psychology Department, had effectively addressed this problem through the development of collaborative, systemic methods. The current review found that these collaborative methods have been effectively continued and maintained. These methods are described in detail with regard to Section J.2 and summarized with regard to Sections J.8, J.9, and J.13. The use of chemical restraint could be construed as punishment, because it frequently involved the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of intramuscular antipsychotic and/or anxiolytic medication was extremely important in differentiating between the necessary utilization of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further assess the circumstances surrounding the use of chemical restraint at CCSSLC, the related documentation was requested for the five most recent incidents that involved the use of chemical restraint. This information was included in the documents provided prior to the onsite review, and is summarized below:	

INDIVIDUAL	DATE	TIME	MEDICATION
Individual #238-#1	1/30/13	3:45 p.m.	Abilify 25 milligrams (mg) by mouth (PO) Discmelt tab Droperidol 10 mg IM
Individual #40	1/27/13	7:30 p.m.	Zyprexa 25 mg IM
Individual #144	1/24/13	12:35 p.m.	Ativan 3 mg IM
Individual #238-#2	1/24/13	5:06 p.m.	Abilify 5 mg PO Discmelt tab Benadryl 25 mg IM
Individual #238-#3	1/24/13	4:22 p.m.	Droperidol 10 mg IM

The individual restraint data was reviewed for the presence and quality of the five components of the documentation the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections and the results of this review were as follows:

1. The information contained in the section of the form following the prompt: "Description of behaviors prior to restraint" was reviewed. This section of the documentation had been completed for all five of these individuals. However,

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		the documentation contained in four of these records only described the overt behavior that necessitated the restraint, and did not discuss the events that precipitated this behavior. For example, the information contained in this section for the 1/27/13 (7:30 p.m.) chemical restraint for Individual #40 was as follows: "Attacking Staff and peers, throwing chairs at staff and peers, hitting staff in the face." The corresponding information for the 1/24/13 (12:35 p.m.) chemical restraint for Individual #144 stated: "Aggression towards fellow peers and staff." This description (which was similar to the others in this sample) could be considered to be responsive to the prompt, which appeared in **bold** type to the left of the section, that stated: "Description of behaviors prior to restraint." However, it did not provide the type of information that would be required to determine the antecedent events to the incident. This information would be essential in determining if the staff or circumstances that preceded the incident provoked the aggressive behavior and/or if the behavior could have been avoided. The documentation for the 1/30/13 (3:46 p.m.) chemical restraint for Individual #238-#1 provided an adequate description of the prior events, including reference to his mental status. Thus, the record review indicated that this section of the documentation was completed in an adequate manner for only one of the five individuals (20%). This information would also be of use to the individual's Psychologist in determining if programmatic strategies could be developed to prevent or minimize the need for chemical restraints in the future. Based on the current available documentation, it was impossible to determine if the aggressive behavior was provoked by an unnecessary demand, or another environmental precipitant that might have been avoided. The Psychology Department should further investigate this observation to ascertain if changes in the format of the documentation and/or additional training are needed. 2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" was completed for all five of these individuals (100%). Specifically, there was a brief narrative that described the attempts to de-escalate the situation. 3. The physiological post-restraint monitoring portion of the documentation was completed for all of the individuals in this sample (100%). However, the documentation for Individual #238-#1, and Individual #144 contained only the respiration rate and the general observation of the individual's status, and not the pulse, blood pressure, and temperature. However, this appeared to be due to the level of the individual's agitation, which may have presented too much of a physical risk to obtain the individual's vital signs. This rationale should have	

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		been identified if this assumption is correct. In addition, it would make sense to begin the monitoring of the vital signs once the individual has calmed to a point that makes this feasible. 4. The face-to-face post-restraint debriefing was also present and completed for all of these individuals (100%). 5. The Chemical Restraint Clinical Review Form, which contained sections for the Pharmacy and Psychiatrist to comment on the appropriateness of the chemical restraint and to provide any information that might be used to prevent further episodes, was completed for all of these five episodes of restraint (100%), within two days of the event. This documentation primarily addressed the pharmacological aspects of the chemical restraint, such as whether the medication utilized was appropriate in light of the individual's history and their overall pharmacological profile. It did not address whether or not the reviewer felt that the specific circumstances warranted the use of chemical restraint and/or whether or not its use could have been avoided. Neither the Psychiatrist nor the Pharm.D commented on the utilization of Droperidol for the 1/30/13 and 1/24/13 episodes of chemical restraint for Individual #238. This medication is an antipsychotic medication with antiemetic properties (i.e., a drug that is effective against vomiting and nausea), which is primarily used as an adjunct to anesthesia. It has been used in hospital Emergency Departments to sedate individuals with a psychotic presentation characterized by extreme aggression/agitation, often in response to a toxic reaction to illicit drug use. Its use in hospital Emergency Departments has declined, following a 2001 FDA Black-Box Alert related to potential cardiac side effects, although it is still utilized in extreme situations. It is not commonly used for psychiatric purposes outside of hospital Emergency Departments, but can be used in extreme situations with appropriate safeguards. Thus, it would be expected that the Psychiatric and Clinical Pharmacy review of the incidents where it was used would have included comments on whether the situation warranted this intervention and if the monitoring was sufficient. The fact that comments were not made, called into question the thoroughness and/or quality of the reviews conducted. Thus, the essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of intramuscular medications were adequately and fully completed for only one of the five individuals in this sample (20%). Although, no instances were found in the documentation to indicate that chemical restraint was definitively used for punishment, there was insufficient information to allow the Facility's staff, or external reviewers to determine that it was not used as punishment or for the convenience of staff. As detailed above, CCSSLC had made	

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		progress with regard to the differentiation of psychiatric symptoms and behaviors that were present on a behavioral basis or in relation to environmental factors. Progress also had been made in ensuring individuals had accurate psychiatric diagnoses that justified the use of psychotropic medication. The rating of noncompliance is based on the finding that the chemical restraint documentation was deficient, and without this it was not possible to conclude that chemical restraint was not being inappropriately used for punishment or for the convenience of staff.	
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.	At the time of the Monitoring Team's previous review, a new initiative related to this provision of the Settlement Agreement had been developed and implemented. It involved the establishment of an interdisciplinary process to ensure the appropriateness and safety of medications prescribed for sedation prior to medical and dental appointments. This process included direct input from the Psychiatrist, the Psychiatric Nurse, the Unit Nurse, the Primary Care Practitioner (PCP), the Psychologist, the Clinical Pharmacist, and the Facility Dentist. These reviews were scheduled to occur on an annual basis for each individual at the beginning of the Psychiatric Clinics, because, with the exception of the Clinical Pharmacist and the Dentist, all of the disciplines identified above routinely participated in these meetings. The scheduling of the reviews at the beginning of these meetings allowed the Pharmacist and the Dentist to participate in an efficient manner. The spreadsheet tracking the occurrence of these meetings indicated they had been completed for the current year for all of the individuals (100%) who required these interventions. In addition, the Quarterly Psychiatric Review documentation for each of the 18 individuals in the review sample (100%) contained a reference to this meeting and the date on which it occurred. Specific concerns related to the quality of the current Desensitization Plans are discussed with regard to Section C.4 of the Settlement Agreement. However, at the time of the prior review, the Facility had developed a methodology for determining who would likely benefit from a Desensitization Plan to reduce the need for pre-treatment sedation. The Facility's plan involved identifying individuals whom they believed were not candidates for a Desensitization Plan, because they had neurological conditions, such as Cerebral Palsy, and required a benzodiazepine medication prior to a dental visit, primarily for the muscle relaxant properties. The other group, which the new decision-tree screened out, consisted of individuals who were thought to have an innate, organically driven, motor restlessness that would make them poor candidates for a Desensitization Plan. The list of individuals who were identified using these filters was contained in a spreadsheet, undated, produced in response to an onsite document request. This spreadsheet contained the names of 60 individuals who would not benefit or did not	Noncompliance

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		need a desensitization plan. The reasons identified for an individual not being a candidate for dental desensitization included "Physiological spasticity" (N=36), "Edentulous" (N=3), and "No Sedation Required" (N=7), or "No problems at Dental" (N=14). Another onsite document requested yielded a spreadsheet that was labeled "CCSSLC: Individuals with Desensitization Baselines." This spreadsheet contained an alphabetical listing of 182 individuals, that included: 1) their residential unit; 2) whether or not their decision-tree and baseline had been completed for a Desensitization Plan for dental and/or medical procedures; and 3) where applicable, the status of each plan. On this list, there were some individuals for whom "NA" was indicated, but when their names were cross-referenced with the list of individuals who were not candidates for Desensitization Plans, they did not coincide with the names on that list. This spreadsheet was not dated, and the most recent date that appeared in any column was 2/21/12. Therefore, either it had not been updated since that time, or there had been no substantial progress since that time. A more recent spreadsheet contained in the Presentation Book included material that was formatted in the same manner, but the most recent entry date for any individual was 11/26/12, which would suggest that it was an updated version of the aforementioned document. This spreadsheet listed 26 unique names in the column titled "Dental Implementation" and 29 unique names in the column titled "Medical Implementation." The Psychiatry Presentation Book also contained two separate, undated lists. The first of these was entitled "Dental Desensitization Plans," which contained 26 names, and the second list, "Medical Desensitization Plans," contained 29 names. These names corresponded to those in the "Dental Implementation" and "Medical Implementation" columns on the spreadsheet. It was impossible from that information to ascertain how far these individuals had progressed in the desensitization process, but it did provide documentation that the Facility had developed plan for those individuals. The purpose of the Desensitization Plans, or other strategies, was to provide the individual with the necessary skills to successfully participate in dental or medical procedures without receiving sedative medication prior to the appointment, or to reduce the need for such medication to the extent possible. Accordingly, the Facility should specifically track information that identifies those individuals for whom the implementation of a behavioral Desensitization Plan or other strategies had resulted in their no longer requiring pharmacological pre-treatment sedation for dental and medical procedures, or resulted in a reduction in the use of pre-treatment sedation. This was not occurring at the time of the current review. It also would be useful to consolidate and simplify the information contained in the various documents described above, into one continuously updated spreadsheet, which clearly indicates the date that it was most recently modified.	

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		The Dental Services Department maintained data on the frequency that intravenous (IV) sedation and pre-treatment oral sedation were required to accomplish successful dental appointments. At the time of the Monitoring Team's previous review, this data indicated that approximately 90 percent of the total monthly dental appointments were accomplished without either pre-treatment sedation or IV anesthesia. During the onsite meeting with the Facility Dentist and the Dental Assistant, they noted that these percentages continued to be approximately within the same range. The following table provides the data for the use of oral sedation, and IV Sedation/General Anesthesia appointments, as well as for those appointments for which no sedation was required for the months of 8/12 through 2/13:	

Dates	Number of Appointments	Number (%) Oral Sedation	Number (%) IV Sedation/ General Anesthesia	Number (%) No Sedation
8/12	135	3 (2.2%)	9 (6.7%)	123 (91%)
9/12	115	6 (5.2%)	7 (6.1%)	102 (88.7%)
10/12	116	5 (4.3%)	8 (6.1%)	103 (88.8%)
11/12	106	3 (2.8%)	6 (5.7%)	97 (91.1%)
1/13	116	4 (3.4%)	0	112 (96.6%)
2/13	175	3 (1.7%)	3 (1.7%)	169 (96.1%)

There were no dental appointments in 12/12 and 1/13 that utilized general anesthesia or IV sedation, and there were no dental appointments in 12/12 that used oral sedation, accordingly 12/12 was omitted from the table. The total of the three columns for each month did not exactly equal 100 percent due to the rounding of numbers.

It should be noted that these frequencies are per appointment, and some individuals did not require sedation for routine appointments, but might require medication for more invasive procedures, such as extractions or extensive cleanings.

The review of the Facility orders for pre-treatment sedation for dental procedures from 1/1/13 through 3/31/13 confirmed that during that time period the orders were primarily for Ativan (a benzodiazepine), in a range from 1 mg to 3 mg, and/or Atarax (an antihistamine with sedative properties) in a range of 25 mg to 50 mg. The Director of Dental Services indicated that if standard, conservative dosages of sedative medications were not effective, the Psychiatry staff and/or the Pharmacy would be consulted for additional recommendations, and, as noted above, the Facility had developed a

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		procedure for the multidisciplinary review of the individuals' pre-treatment sedation in the context of the Quarterly Psychiatric Reviews. The IV anesthesia monitoring was very detailed. The Consultant who actually administered the anesthesia also performed the monitoring. The monitoring for the physiological effects of the oral pre-treatment sedation was initiated in the residences, as the medication itself was administered at those locations, 60 to 90 minutes prior to the appointment in the Dental Clinic. Thus, the pre-administration monitoring of the individual's physiological status was performed at the residence and then transitioned to the Dental Clinic at the time of the appointment. After the work in the Dental Clinic was completed, and when the Dental staff felt it was appropriate to release them, the individual returned to their residence. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments is discussed in more detail with regard to Section Q. As noted above, the Facility had devoted a great deal of attention to determine which individuals required plans to minimize the use of pre-treatment sedation, and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 1/1/13 through 3/31/13 indicated that the majority of pre-treatment sedation at CCSSLC was utilized for medical appointments. Close examination and inspection of the entire spreadsheet indicated that this ratio varied considerably over time, but the observation was consistent. The frequency of pre-treatment sedation orders for medical procedures exceeded the number for dental procedures. The majority of the orders for medical procedures were for Ativan, in a range of 1 mg to 2 mg and/or Atarax, in a range of 25 mg to 50mg, as well as chloral hydrate in a range of 500 mg to 1000 mg. Overall, the medications utilized appeared to be appropriate and were prescribed in moderate dosages. As indicated above, the Psychology Department had begun to develop Desensitization Plans for medical procedures, but this process was not as developed as for dental procedures. CCSSLC had an adequate process in place for coordinating pre-treatment sedation for dental procedures with other medication supports and services as appropriate, by Psychiatry, Pharmacy, and medical services. However, there did not appear to be a well-developed monitoring system for the use of pre-treatment sedation for medical procedures. The finding of noncompliance for this provision was based on the observation that fully	

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		effective, operational Desensitization Plans to reduce the need for pre-treatment sedation for medical and/or dental procedures had not yet been completely developed or implemented, nor was a system in place for coordinating the pre-treatment sedation for medical services.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The Monitoring Team's previous reviews 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 residing at the Facility, because many of these individuals presented with complex psychiatric disorders. The current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this was a reasonable estimate. During the 4/1/13 interview with the professional support staff of the Psychiatry Department, a specific inquiry was made as to whether the above determination was supported by an empirical analysis of the time required to fully meet all of the provisions of the Settlement Agreement, including participation in the ISP process. The Psychiatry team responded that both the prior locum tenens Psychiatrist and the regular Consulting Psychiatrist had previously commented on this issue and they were both in agreement that two full-time Psychiatrists or equivalents would be adequate. However, these opinions were not based on an empirical time allocation analysis, but rather were primarily subjective in nature. Accordingly, it was recommended that such an analysis be performed, and the Facility was able to produce written documentation that specified the calculations and assumptions that went to their findings. This documentation indicated that CCSSLC had taken into account the time required to administer direct clinical services to the 114 individuals prescribed psychotropic medication, as well as attend their ISP meetings and complete the CPEs on an annual basis, and indicated that two full-time psychiatrists would be adequate. These determinations also took into account the continued involvement of the consulting psychiatrist, as well as the support provided by the four members of the psychiatry support team. At the time of the previous review, the Facility was relying on one part-time Consulting Psychiatrist to provide the day-to-day psychiatric care to all of the 114 individuals prescribed psychotropic medication. His weekly allotment of time recently had been decreased from twelve to eight hours (two four-hour blocks per week). This remaining allotment of time equated to 20 percent of one FTE Psychiatrist. As noted above with regard to Section J.1, the Consulting Psychiatrist was Board Certified in Adult Psychiatry. An additional locum tenens Psychiatrist was currently working on site, on a full-time basis, and was expected to remain for at least the rest of the calendar year. This staff member's background is described with regard to Section J.1. His time was devoted to completing the CPEs for the individuals prescribed psychotropic medication. In addition,	Substantial Compliance

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		the Facility had been able to recruit a new full-time Psychiatrist who would also assume the administrative responsibilities of the Director of Psychiatric Services. Besides her administrative responsibilities, this Psychiatrist also was expected to be responsible for the direct clinical care of a portion of the residents. However, the distribution of the clinical caseloads between the Consulting Psychiatrist and the new Director of Psychiatric Services had not yet been determined. In addition, 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 they provided, made it possible to maximally utilize the amount of psychiatry time that was available to the Facility. The addition of the new full-time Director of Psychiatric Services and the full-time locum tenens Psychiatrist, along with the continued service of the Consulting Psychiatrist (who has been there for several years), increased the total amount of psychiatric time to 2.25 FTEs. CCSSLC has been found to be in substantial compliance with this provision of the Settlement Agreement. The Facility's analysis of the Psychiatrists' time allocation indicated that two FTEs should be sufficient, and a member of the Monitoring Team reviewed this analysis and found it to be reasonable. The Facility is aware that if the current locum tenens Psychiatrist were to leave and/or was not replaced with another full-time Psychiatrist, this would change the finding to noncompliance in future reviews.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated in the Monitoring Team's previous reports, CCSSLC had developed an initiative to complete a thorough CPE for each individual prescribed psychotropic medication, which they believed would meet the requirements set forth in the Settlement Agreement. The review of the active records of 18 individuals receiving psychotropic medication identified a CPE for 11 of the 18 individuals in the sample (61%). The individuals in the sample for whom a recent CPE could not be located (followed by date of last CPE) were as follows: Individual #218 (2/29/12); Individual #238 (8/12/11); Individual #95 (2/9/12); Individual #53 (3/1/12); Individual #283 (3/8/12); Individual #34 (3/12/12); and Individual #13 (2/28/12). All of the CPEs contained in the sample (including those that were out-of-date) fulfilled the criteria specified in the Settlement Agreement (100%). The review of the spreadsheet dated 4/2/13, which the Facility maintained to track the completion and annual updating of the CPEs, indicated that a CPE had been completed	Substantial Compliance

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		for all of the 114 individuals prescribed psychotropic medication, including the 18 individuals mentioned above. However, 27 of these individuals were identified as currently delinquent, as they had not been updated within the last 12 months. This included the seven individuals identified in the sample described above. Thus, at the time of the onsite review, a CPE had been updated within the last 12 months for 87 of the current 114 individuals who were receiving psychotropic medication (76%). In order to further assess the integrity of the spreadsheet, an additional sample of ten individuals was requested during the onsite review to augment the sample derived from the record reviews. This brought the total number of CPEs reviewed to 28 of the 114 individuals (25%) receiving psychotropic medication. The CPEs of the additional ten individuals (and the date of completion) were those of: Individual #172 (2/25/13); Individual #325 (2/28/13); Individual #318 (3/1/13); Individual #109 (2/27/13); Individual #158 (2/26/13); Individual #343 (2/4/13); Individual #58 (2/19/13); Individual #295 (not yet signed or dated); Individual #47 (3/12/13); and Individual #298 (2/11/13). The format and content of these documents also met the criteria specified in the Settlement Agreement, and had been completed and/or updated within the prior year. The CPEs included the components set forth in Appendix B of the Settlement Agreement. They began with a description of the documents reviewed and the individuals interviewed in the process of gathering the information necessary to complete the CPE. This section of the CPEs indicated that, in addition to the extensive document reviews, the Psychiatrist interviewed both direct support professionals and other members of the staff, including the clinicians. Family members also were contacted, if possible, and the individual was interviewed. However, if the individual was incapable of verbal interaction, there was a period of direct observation. The diagnostic sections of the records provided a thorough description of the symptoms that supported the psychiatric diagnosis, and the Bio-Psycho-Social-Spiritual formulation section presented a cohesive description of the rationale for the individuals' diagnosis and the impact this psychiatric disorder had on his/her functional status. The quality of the individuals' psychiatric diagnosis is also discussed with regard to Section J.2. In summary, based on a review of the sample of individual records, the psychiatric diagnosis for all 18 of the individuals (100%) prescribed psychotropic medication contained adequate documentation to justify the individuals' psychiatric diagnosis. At the time of the previous review, CCSSLC was found in substantial compliance with this provision, because the CPEs met the requirements of the Settlement Agreement and	

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		were also up-to-date for all of the individuals prescribed psychotropic medication. The only exception was a few individuals who had been admitted to the Facility in close proximity to the date of that review. The current review found that the quality of the documentation contained in the CPEs continued to meet the requirements of the Settlement Agreement, but for 24 percent of individuals prescribed psychotropic medication, they were not current. The onsite interviews with the psychiatric staff indicated that this was due to unexpected and unpreventable circumstances that resulted in the locum tenens Psychiatrist, who had been assigned to complete the CPEs for the prior two years, not returning to the Facility. These unfortunate circumstances occurred shortly before his scheduled return to the Facility, and a replacement had only been secured within the several weeks prior to the Monitoring Team's onsite review. The new schedule for the updating of CPEs was expected to result in the completion of those CPEs that were overdue in the coming weeks. Thus, the Monitoring Team views these circumstances as meeting the criterion set forth in Section III.D of the Settlement Agreement. In this section, the parties included the following language: "Noncompliance with mere technicalities, or **temporary failure to comply during a period of otherwise sustained compliance**, shall not constitute failure to maintain substantial compliance." (Emphasis added.) As a result, the Facility has maintained the finding of noncompliance with the understanding that for a substantial compliance rating to continue during the next review, corrections to the timeliness of the updates will be corrected and sustained.	
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	A spreadsheet, updated on 4/3/13, listed the individuals that had been administered the Reiss Screen for Maladaptive Behavior and the date of administration. The majority of these had occurred in March of 2013. The Facility's policy was to repeat the Reiss Screen for all of the individuals not prescribed psychotropic medication each year. This was not a requirement for substantial compliance, but was how the Facility had chosen to comply with the Settlement Agreement. Each of the Monitoring Team's initial three reports included the results of an analysis of a distinct 20 percent sample of individuals who had been administered the Reiss Screening instrument. This methodology verified the accuracy of the data by comparing the information contained in the spreadsheet to a copy of the actual Reiss scoring sheet for the corresponding individuals in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate. A request for the names of the individuals whose score on the Reiss (CCSSLC utilized the commercially available computer scoring for the Reiss) was above the cut-off score that prompted further clinical assessment or clear justification for not conducting a CPE, indicated that this year there were six scores above the clinical cut-off score.	Substantial Compliance

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	psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The date of the Reiss Screening in parentheses "()" and the total Reiss Score in "[]" were as follows: Individual #14 (11/29/12) [14]; Individual #300 (9/26/12) [16]; Individual #177 (1/10/13) [9]; Individual #142 (12/11/12) [6]; Individual #38 (10/1/12) [13]; and Individual #355 (3/15/13) [23]. However, four of these six individuals were already followed in the Psychiatry Clinic and had been administered the Reiss Screening as part of a comprehensive psychological re-evaluation performed by the Department of Behavioral Services. These individuals were as follows: Individual #300, Individual #177, Individual #142, and Individual #38. The spreadsheet and the copy of the actual Reiss Scoring Sheet indicated that the Reiss Screening for Individual #14 was administered on 11/12/12. The CPE for this individual was completed 3/14/13. The narrative sections of the CPE indicated that he had a diagnosis of a Bipolar Disorder, which manifested itself in mood lability, as well as verbally and physically aggressive behavior. However, he adamantly refused to take psychiatric medication, and, for this reason, was not formally followed in the Psychiatric Clinics, although he was well known to the staff of the Psychiatry Department and the Consulting Psychiatrist. Individual #355 was administered the Reiss Screen on 3/15/13. His elevated score (23) was responded to with a CPE, which was completed on 3/18/13. The historical sections of this document indicated the individual had been evaluated by the Psychiatric Department and had been prescribed psychotropic medications, which had subsequently been tapered and discontinued without any adverse effects. Although he was well known to the Psychiatry Department, he was no longer receiving psychotic medication and, thus, was not followed in the Psychiatric Clinic at this time. Both of these CPEs were thorough and met the requirements of the Settlement Agreement. The current review focused on those individuals for whom the Reiss Screen had been administered since the Monitoring Team's prior review. Since the last review, the Reiss Screen was not administered to individuals who were admitted to CCSSLC and who were prescribed psychotropic medication, because they were evaluated with a psychiatric examination instead of a Reiss Screen for Maladaptive Behavior. The yearly screenings with the Reiss instrument essentially functioned as an annual screening for all of the individuals not followed in the Psychiatric Clinics. As stated previously, this was the Facility's choice for complying with the Settlement Agreement, as opposed to using other valid methodologies (i.e., defining changes of status that would necessitate rescreening and conducting screenings for individuals meeting such criteria). The finding of substantial compliance is carried over from the previous reviews, because the annual screening of all individuals not receiving psychotropic medication provided a mechanism for assessing if these individuals had experienced a change in their status and would benefit from a psychiatric assessment. In addition, those individuals with	

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		elevated scores who were not already being followed in the Psychiatric Clinics had been evaluated with a CPE that met the requirements of the Settlement Agreement.	
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 integration between Psychiatry and Psychology Services was apparent in the interviews with the Director of Psychological Services, the Consulting Psychiatrist, and the other members of the Psychiatry Department. In addition, on 4/2/13, the observations of the Psychiatric Clinics indicated that the Psychologist played an important role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. In terms of case formulation, the Monitoring Team's initial reviews revealed a persistent deficit in this collaboration. Specifically, this was the co-identification of the same behaviors as being both a "target behavior" of the prescribed psychotropic medication, and also being present on a learned or behavioral basis in the Functional Analysis and the PBSP. As indicated in previous reports, it is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The Psychiatry Department, working in conjunction with the Psychology Department, had developed a system, which was responsive to recommendations in the Monitoring Team's previous reports, to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. This subject is also relevant to Sections J.2 and J.9 of the Settlement Agreement, where it is discussed in further detail. In summary, these innovations clarified the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed. The related PBSPs the Psychology Department developed included a section entitled: "Psychiatric Information" and described how the psychiatric disorder would affect the behavioral presentation for those individuals for whom this was relevant. This coordinated, complimentary documentation was evidence of collaboration between the Psychiatry and Psychology Departments with regard to combined case formulation. The accuracy and integration of the behavioral data into the Psychiatry Clinic documentation is discussed in detail with regard to Section J.13. The Psychiatry Department's utilization of objective measurement tools is discussed in Sections J.2 and J.13. The primary disciplines that attended the Monthly and Quarterly Psychiatric Clinics were Nursing, Psychiatry, Psychology, Medicine, a direct support professional, and a Qualified Developmental Disabilities Professional. However, disciplines such as Occupational Therapy and Physical Therapy were not able to attend the individual Psychiatry Clinic reviews due to time constraints. These disciplines often did attend the ISP meetings.	Noncompliance

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		The ISP Meeting documentation was reviewed for the 18 individuals in this sample. This review indicated that a member of the Psychiatry Department attended a recent individual ISP Meeting for none of the individuals in the sample (0%). A request for a list of ISP meetings that a member of the Psychiatry Department had attended from 4/1/12 through 4/1/13 indicated that a member of the Psychiatry Department had attended the ISP meetings for 22 individuals. Within the last six months a member of the Psychiatry Department had attended eight ISPs, which were those of the following individuals followed by the (date of ISP): Individual #313 (9/7/12); Individual #176 (9/10/12); Individual #94 (9/18/12); Individual #20 (9/27/12); Individual #354 (11/27/12); Individual #167 (1/10/13); Individual #115 (3/21/12); and Individual #98 (4/3/13). For the sample of 18 individuals, the documentation from the ISP meetings fully reflected the psychiatric aspects of the individuals' treatment for none of the individuals (0%). There was a discussion of the psychological treatment plan and reference to the individuals' psychotropic medication, but no detailed information was included to reflect the psychiatric aspects of their presentation. In addition, the ISPs did not include action plans related to the implementation of the psychiatric treatment plans, including, for example, the collection of objective data necessary to determine the efficacy of the medication. As a result, the integration of the psychiatric treatment with other supports was not evident in the individuals' ISP documentation. The rating of noncompliance for this provision of the Settlement Agreement is due to the lack of overall integration of psychiatric services into an individual's ISP. The Psychiatry Department had begun an initiative to have a member of the Department (either a Psychiatric Nurse or a Psychiatry Assistant) attend the ISP of each individual receiving psychotropic medication. The Department also intended to prepare the documentation representing the individual's psychiatric treatment, and then make certain this information is placed directly into the ISP documentation, which should ensure consistency. During the Monitoring Team's meetings with the members of the Psychiatry Department on 4/4/13, this was discussed, at which time they indicated a psychotropic medication treatment plan recently had been developed. This plan was designed to be completed in conjunction with the individual's Annual Integrated Risk Rating Form for the ISP meeting and will become an integral part of the psychiatric documentation in the ISP. In response to a request made during the onsite review, the Facility produced the draft outline of this document and five recently completed documents for the following individuals with the date of the corresponding ISP: Individual #268 (4/4/13), Individual #321 (undated), Individual #184 (4/1/13), Individual #88 (3/26/13), and Individual	

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		#53 (3/22/13). The documents contained the following 12 major headings: ▪ Demographics/Brief History Statement; ▪ Psychiatric Diagnosis and Symptoms of Diagnosis: Table Axis I, II, III; ▪ Diagnoses for Axis IV, and V; ▪ Target Symptoms Monitored; ▪ Psychological Assessment; ▪ Combined Behavioral Health Review/Formulation; ▪ Psychoactive Medication: Psychiatric Drugs in Use Table; ▪ Risk of Medication; ▪ Risk Benefit Discussion; ▪ Non-pharmacologic Treatment; ▪ Patient Preferences; ▪ Past Pharmacotherapy; and ▪ Future Plans. Review of the five completed versions of these documents indicated the discussion of the subject matter related to the major heading was sufficiently detailed, and taken in conjunction with the psychiatric material in the related Integrated Risk Rating Form, would fulfill the documentation aspects of this provision, if the quality can be maintained over time. Substantial compliance with this provision also would require that a member of the Psychiatric Team be present at the individual's ISP to lead the discussion of this material with the other members of the IDT, unless the team provided adequate justification for a member of the Psychiatric Team not being present. The current finding of noncompliance for this provision reflected the fact that a member of the Psychiatry Department had not attended any of the ISP meetings for the 18 individuals in the current sample and adequate justification was not provided for their not attending, and the corresponding psychiatric documentation in these ISPs was inadequate. In addition, a member of the Psychiatry Department had only been able to attend the ISP Meeting for eight individuals within the prior six months.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as the documentation that was found in the sample of 18 records of individuals receiving psychotropic medication. The Monitoring Team's previous reports revealed a significant deficiency in this process related to the degree to which behaviors identified as being targets of a psychotropic medication also were identified in the Functional Analysis and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely	Noncompliance

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	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.	feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. The differentiation of the problematic behaviors the individual presented is directly related to the concluding requirement of this provision, specifically: "the need to minimize the need for psychotropic medication to the degree possible." As long as these deficiencies existed, it would increase the risk that the individual could be prescribed unnecessary psychotropic medication. In addition, the individual would not receive the behavioral supports appropriate to address the problem. The changes in the Psychiatry and Psychology Departments' documentation addressing this issue are described with regard to Section J.2, and summarized with regard to Section J.8. The Facility's status with regard to "minimizing the need for psychotropic medication to the degree possible" is discussed in detail with regard to Section J.11. In its efforts to address the issues related to the misidentification of behaviors, the Psychiatry Department had modified the format for the Quarterly Psychiatric Reviews so that it would contain more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored target behaviors. Reportedly, the newly formatted Quarterly Review documents had been incorporated into the records of all of the individuals prescribed psychotropic medication. The CPEs that met the quality standards of the Settlement Agreement also provided discussions addressing this differentiation. These discussions primarily appeared in the Bio-Psycho-Social-Spiritual Formulations section of the CPEs, and the discussions of the differential psychiatric diagnoses, as well as the Quarterly Review documentation discussed above. In addition, the Psychology Department had added a section to their documentation entitled: "Psychiatric Information," which also addressed this problem. All of these methods are described in more detail with regard to Section J.2. This provision also stipulates that this information should be discussed during the ISP meeting and included in the ISP meeting documentation. As noted with regard to Section J.8, a member of the Psychiatry Department had not been able to attend any of the ISPs of the 18 individuals (0%) in the sample of individuals receiving psychotropic medication, and none of the ISPs reviewed in this sample contained adequate documentation to address the stipulations contained in this provision. A member of the Psychiatry	

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		Department had attended the ISP for eight individuals over the prior six months, as described with regard to Section J.8. In order to fulfill the requirements of this provision, this documentation should explicitly describe the deliberations leading to the decision that the use of psychotropic medication represented the least intrusive and most positive intervention to treat the psychiatric disorder. The team must also determine whether the individual will best be served primarily through behavioral, pharmacological, or other interventions. In addition, the documentation in the ISP should specify non-pharmacological treatment, interventions, or supports to address signs and symptoms of the disorder in order to minimize the need for psychotropic medication to the lowest degree possible. Although the existing documentation in the: a) Behavioral Support Plans; b) Quarterly documentation; and c) CPEs (as discussed in detail with regard to Sections J.2, J.6, J.8, and J.13) contributed to the fulfillment of these requirements, these documents did not reflect teams' roles in reviewing this information and making decisions. It would be helpful to explicitly refer to these three factors in both the Psychology and Psychiatry sections of the individual record, as well as the ISP or ISPA documentation in order to directly address this provision of the Settlement Agreement and avoid any confusion. Also, as noted above, the deliberations and supporting evidence that led the team to these conclusions should be explicitly stated, rather than a simple opinion that these criteria had been met. As described with regard to Section J.8, the Facility has developed a format that appeared to fulfill the requirements of the Settlement Agreement for s Sections J.8 and J.9 going forward, but this cannot be definitively determined until the actual documentation is analyzed during the Monitoring Team's future reviews. The finding of noncompliance for this provision was primarily based on the lack of attendance by a member of the Psychiatry Department at the ISP meetings or justification that their presence was not needed, as well as the inadequacies in the deliberation of the IDTs in relation to the use of behavioral, pharmacological, or other interventions, in combination or alone, and the related documentation in the ISPs.	
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	This provision of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications. The Monitoring Team's initial reports indicated that these discussions primarily appeared in the HRC section of the record, as well as the PBSP, and usually concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors that were identified as the targets of the psychotropic medication.	Noncompliance

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	effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	At the time of the previous review, the Facility had responded to the recommendations contained in the Monitoring Team's prior reports. Specifically, the Facility was providing more information related to the risk-versus-benefit equation for the psychotropic medications in the Quarterly Psychiatric Reviews and the CPEs. The current review of a sample of the Quarterly Psychiatric Reviews and/or CPEs found an improved discussion of the risk-versus-benefit analysis in 15 of the 18 individual records (83%). The specific records that contained this information were those of Individual #40, Individual #61, Individual #218, Individual #295, Individual #47, Individual #354, Individual #13, Individual #53, Individual #95, Individual #34, Individual #283, Individual #359, Individual #136, Individual #72, and Individual #237. These discussions included information regarding the potential and realized side effects, as well as the potential and/or realized therapeutic benefits of the medication, including the rationale for those determinations. Not surprisingly, the list of individuals for whom the improved risk-benefit determination could be identified, paralleled the list of individuals for whom it was possible to discern that the prescribed psychotropic medications had been effective. They also tended to be individuals who were prescribed fewer psychotropic medications. Thus, this finding is similar to the determination of efficacy discussion related to Section J.13. The following three individual records (17%) did not contain the sufficiently detailed information included in the records identified above: Individual #318, Individual #172, and Individual #238. These individuals tended to be prescribed more psychotropic medications and had also experienced more frequent changes to their medications, making it difficult to establish an adequate baseline with which one could make a reasonable determination of efficacy. The Facility had developed a tool to be utilized in the review of the psychotropic medications at the HRC meetings. This tool included specific prompts to facilitate the review of the major considerations that both clinicians, and the members of the Human Rights Committee should take into account when assessing the risk-versus-benefit of prescribed medications. The implementation of this instrument had improved the quality of the discussions and the related documentation as based on the observation of this information over several monitoring review cycles. On 4/3/13, a member of the Monitoring Team attended the HRC meeting. The reviews that occurred at this meeting were thorough, detailed, and comprehensive. The observations of the deliberations of the HRC meetings during prior onsite reviews were also consistent with these findings. At the time of the Monitoring Team's previous reviews, it was noted that the thoroughness of these discussions was not always reflected in the documentation subsequently found in the record reviews. The Facility	

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		had responded to these recommendations by changing the format of the Human Rights Committee Meeting minutes so they covered the salient aspects of the discussions in a succinct manner. Since the last review, the Facility had continued to make progress. However, the continued finding of noncompliance for this provision is due to the recurrent deficiencies in the risk-versus-benefit discussions that occurred in 17 percent of the sample of records reviewed. As noted above, a number of the individuals whose records did not contain adequate risk-versus-benefit discussion were prescribed multiple psychotropic medications. This factor also adversely effected the determination of efficacy for these medications, as referenced above and discussed with regard to Section J.13.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	CCSSLC had continued its policy of reviewing individuals whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" for the prior six months were reviewed. The Consulting Psychiatrist, Director of Pharmacy Services, an Attending Physician, a member of the Psychology Staff, a Nurse from the Quality Assurance Department, and a Psychiatry Assistant attended these meetings. Specifically, for the months between May 2012 and January 2013, the PCP, Psychiatrist, Psychiatric Nurse, Psychologist, and the Psychiatric Assistant attended the clinical reviews at least 88 percent of the time, and the Pharmacist attended 75 percent of the time. The meeting notes indicated that the group engaged in detailed, case-centered discussions of individuals whose medication regimens met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for specific individuals. Documentation from the 3/29/13 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 3/22/13. As per recommendations made in the Monitoring Team's previous reports, the Facility tracked the status of the individuals admitted from the community within the last year in a separate database, and those numbers are discussed later in this section. The data for the remaining 109 individuals indicated that 19 of these individuals (17%) were receiving two or more medications from the same class, and 50 individuals (46%) were receiving three or more medications, regardless of class. Of these, nine individuals were in both the three-or-more and the intra-class categories. The specific information regarding the number of individuals receiving multiple medications was as follows: ▪ Two medications = 32 individuals; ▪ Three medications = 26 individuals; ▪ Four medications = 22 individuals; ▪ Five medications = one individual; and	Noncompliance

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Six medications = one individual.
Historical data from several years ago was not available for comparison. However, monthly comparative data was available from November 2010. It should be noted that individuals prescribed three or more psychotropic medications and also meet the criteria for intraclass polypharmacy (as two of these medications are from the same class) are only counted once. Thus, as the 19 individuals who met the intraclass polypharmacy criteria were also subsumed into the three or more category the total of individuals defined as meeting the criteria for polypharmacy remained 50. Tabular representation of the data is as follows:
<table>
<tr><th>DEFINITIONS OF POLYPHARMACY</th><th>October 2010</th><th>March 2013*</th></tr>
<tr><td>Number of individuals receiving two or more meds from the same class</td><td>37</td><td>19</td></tr>
<tr><td>Number of individuals receiving three or more meds regardless of class or indication</td><td>81</td><td>50</td></tr>
<tr><td>Total number of individuals on polypharmacy</td><td>81</td><td>50</td></tr>
<tr><td>Total number of individuals receiving psychotropic medication</td><td>145</td><td>109*</td></tr>
<tr><td>Percentage patient population receiving psychotropic medication whose medications met the criteria for polypharmacy</td><td>56%</td><td>46%</td></tr>
</table>
*These numbers did not reflect the five individuals who were admitted in the previous 12 months.

This provision of the Settlement Agreement also stated it was necessary “to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.” Thus, this provision also related to the documentation that prescribed medications could be empirically demonstrated to be effective. The discussions with the Psychiatry Department regarding the individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy indicated that the Psychiatric Team believed that many of these medications were essential for the individuals’ stability. This belief also was reflected in the minutes of the monthly Psychiatry Polypharmacy Reduction Committee Meetings. Subsequent to the prior review, the Facility had implemented the recommendation to develop a categorical approach to clinically justify or systematically pursue reductions in an individual’s medications. The two primary categories were derived from these clinical principles. The first category was “No current plan to reduce medications because of clinical acuity.” The second major category was “Individuals for whom a plan to actively reduce one or</td><td></td></tr>
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		more of their medications has been identified." The Polypharmacy Committee reviewed five individuals in depth every month, and, thus, it would require a year to review the 50 individuals who meet the criteria for polypharmacy. This methodology was implemented in September 2012, and as of the most recent review, 50% of those who meet the criteria for polypharmacy were in Category One, and 49% were in Category Two. The observation that the Facility would not have been able perform the reviews alluded to above for 99 percent of the individuals prescribed polypharmacy at the rate of five per month would suggest that some of these classification decisions were based on their prior clinical knowledge of these individuals. Thus, they would be subject to further review with the progression of the process. As noted above, the Facility tracked, as a separate category, those individuals admitted from the community who were prescribed multiple psychotropic medications. At the time of the onsite review, that group included five individuals. Two of these individuals were admitted to CCSSLC within the last 60 days. The range in the number of psychotropic medications these individuals were receiving at the time of admission was two to five, with an average of 3.5 per person. There was an extensive discussion of the evidence that would be required to support the conclusion of justifiable polypharmacy with the members of the Psychiatry support staff during the onsite review. An example of information that could represent sufficient documentation included evidence that the individual experienced a significant deterioration in their status following a decrease in their medication, or there was significant improvement following the introduction of a new medication or an increase in the dosage. This evidence does not need to consist of a mathematical proof of efficacy, but should provide more documentation than a simple opinion that the medications continued to be necessary. As noted above, the Psychiatry Department had made only modest progress in reducing the use of polypharmacy with psychotropic medication for the individuals who resided at CCSSLC. The current finding of noncompliance for this provision primarily related to the lack of a process to empirically justify the continued use of polypharmacy, as appropriate, and given the relatively high rates of polypharmacy, a lack of evidence that it had been eliminated unless it was justified.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools	This provision of the Settlement Agreement and the Health Care Guidelines mandate systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related	Substantial Compliance

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	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.	to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this side effect monitoring also includes the latency between the time the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician. Review of the sample of the records of 18 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months and had been performed at least every six months) and present for all of the individuals in this sample (100%). The records of the 18 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 17 of the 18 individuals (94%). The one individual for whom documentation of the review by the prescriber was inadequate was Individual #318. The second page for all the MOSES evaluations in the record was missing, and that is where the date of the review by the prescriber is entered into the record. Thus, there was insufficient documentation to confirm that the MOSES evaluations were reviewed in a timely manner for this individual. The purpose of the DISCUS was to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of individuals indicated that only 16 of these individuals were prescribed antipsychotic agents that would require monitoring with the DISCUS. The documentation contained in the records of these 16 individuals indicated that the DISCUS had been completed as specified for all of these individuals (100%). These evaluations had been reviewed and signed in a timely manner for all of these individuals (100%). The results indicated that the Facility had maintained the progress noted in prior reviews. The date the MOSES and DISCUS evaluations were performed was recorded in the Psychiatric Quarterly Review documentation, as were the results for each and whether or not an additional action was required. The presence of any significant side effects, as well as the action required, would be discussed in the section of this document, which represented the Psychiatrists' Narrative Summary. Each Quarterly Review contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES are also necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who also were receiving	

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		antipsychotic medication. A list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals who were receiving Reglan, but not also prescribed psychotropic medication. The rationale for this distinction was that the nurses in the individuals' residences administered the evaluations for these individuals, rather than the Psychiatric Nurses. This process indicated that, as of 4/1/13, ten individuals were receiving Reglan, but were not prescribed medication for a psychiatric disorder. The following sample of four individuals (40%) who fit the above criteria was selected, and included: Individual #113, Individual #205, Individual #270, and Individual #137. The review of the records related to the MOSES evaluations for this group of individuals indicated that the examination had been performed every six months as required for three of the individuals in this sample (75%). There was a gap in the MOSES forms from 3/15/12 to 3/4/13 for Individual #137. All of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner (100%). The same sample of individuals receiving Reglan was used to evaluate the completion of the DISCUS. The results of this review indicated that the DISCUS evaluations were completed every three months as required for three of the four individuals (75%). The documentation indicated that the prescribing physician had reviewed three of the four evaluations in a timely manner (75%). The results for Individual #137 were compromised by the fact that the second pages of the DISCUS forms that contained both the date and signature of Nurse completing the evaluation, as well as that of the prescriber were missing. The front pages of two DISCUS forms provided for this individual indicated that the prior examination had been completed on 12/12/12 and 9/3/12, which would suggest that the examinations were being completed on schedule. However, without the signature pages, it is not possible to confirm this. During the onsite review, a member of the Monitoring Team also inquired about the degree of training that the Unit Nurses received with regard to performing the DISCUS evaluation. The Psychiatry Team indicated that all of the nurses receive both initial training as well as annual updates. This training was quite extensive and included both the review of videotape, as well as a required post-training competency test to assess skill acquisition. The Facility's Psychiatry Nurses were instructors for the training. In order to verify that the training was taking place, attendance for the prior year was reviewed. The Psychiatric Nurses also supplied the results of post-training tests and the DISCUS evaluations that the Nurses conducted after viewing the videotapes to illustrate they were able to utilize the correct methods for performing the evaluations. The content of the training materials, the documentation of attendance, and the production of	

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		the testing materials/results indicated that the Unit Nurses were receiving adequate training to competently complete the DISCUS evaluations for those individuals prescribed Reglan. The MOSES evaluation material has detailed instructions on how to conduct the evaluation embedded into the actual testing material. This evaluation was designed for completion by staff with a nursing degree. The continued finding of substantial compliance for this provision is based on the fact that the DISCUS and MOSES were both completed as required and reviewed in a timely manner for 94 to 100 percent in the sample of the individuals prescribed antipsychotic medication. For individuals prescribed Reglan, problems were noted for only one individual each for MOSES and DISCUS reviews.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	This provision of the Settlement Agreement addresses processes essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "The Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 18 individuals (16% of the total prescribed psychotropic medication) indicated that a description of the specific symptoms supporting the psychiatric diagnosis of record could be identified for all of the individuals (100%). This issue is discussed in further detail with regard to Section J.2. The narrative related to Section J.2 also contains a detailed review of the updated process and documentation related to establishing a psychiatric diagnosis at CCSSLC. The current CPEs contained sections that discussed the diagnosis, and the Quarterly Psychiatric Reviews included the DSM-IV Diagnostic Checklists, which verified that the diagnosis of record for that individual met the specific diagnostic criteria for each Axis I and/or Axis II diagnosis applied to that individual. These Checklists had been developed and implemented at the time of the prior review. In addition, in the Monitoring Team's previous reports, a discussion had been included regarding the utility of developing a method that would more specifically track the symptoms of the individual psychiatric disorder, as well as the identified "target behavior." The Psychiatry Team had responded to this by developing a psychiatric symptoms tracking scale. It defined 21 symptoms that related to the Major Axis I psychiatric diagnoses. As discussed with regard to Section J.2, these instruments were now fully implemented. The Unit Nurses completed these ratings for the symptoms that were specific to the individual, as determined by the Consulting Psychiatrist and the other members of the interdisciplinary Psychiatric Clinic teams. This data provided a measure of the frequency and intensity of these symptoms, which the Psychiatrist referenced in the narrative section of the Monthly and Quarterly	Noncompliance

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		Psychiatry Notes. During the onsite interview with the Psychiatric Team, they indicated that the Department was considering replacing this checklist with an instrument that had been statistically validated and was in more widespread use. The two-page Quarterly Review documentation included 18 specific domains of clinically relevant information, which collectively covered the broad categories of the individuals' psychiatric diagnosis and current status. The sub-sections of this document included the prescribed psychiatric medications, as well as side effect and behavioral considerations, the medical diagnosis in addition to the status of any neurological involvement, and recommendations for future interventions and monitoring. This information was presented in a logical format that made it relatively easy to absorb the content, despite the amount of information presented. As discussed with regard to Sections J.8 and J.9, observation of the 4/2/13 Psychiatric Clinics indicated there was an interdisciplinary discussion of the clinical issues involving the individual that informed the decisions regarding the utilization of psychotropic medications. This provision of the Settlement Agreement also addresses the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were now effectively addressed through the methods described above and reviewed in detail with regard to Section J.2. As discussed with regard to Section J.2, the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed were monitored to assess the efficacy of the medication. In addition, the relationship between the psychiatric disorder and the behaviors addressed by Psychology were clarified in the Bio-Psycho-Social-Spiritual formulation of the CPE, the Quarterly Psychiatric Review documentation, and the Psychiatric Information section of the Positive Behavior Support Plan. Another requirement of this provision of the Settlement Agreement related to the efficacy of the prescribed psychotropic medication. In 15 of the 18 records reviewed (83%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. These records were of the following individuals: Individual #136, Individual #72, Individual #354, Individual #47, Individual #13, Individual #295, Individual #40, Individual #218, Individual #53, Individual #318, Individual #95, Individual #34, Individual #283, Individual #359, and Individual #237. These tended to be individuals receiving fewer psychotropic medications. The individuals for whom the efficacy of the medication had not been documented were: Individual #318, Individual #172, and Individual #238. These individuals were prescribed multiple psychotropic medications and tended to have more frequent	

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		changes in the prescribed medication, making it more difficult to establish the baseline data necessary to make a determination of efficacy. As noted in the discussion related to Section J.11, a number of individuals at CCSSLC continued to be prescribed multiple psychotropic medications. The determination of efficacy for each of these medications, naturally, becomes mathematically more complex, and this problem was further compounded when changes in those medications were made without sufficient time to establish a new baseline for an additional medication. In addition to the lack of sufficient chronological data, the major impediment to determining if an individual's medications were effective was the number of medications that the individual was receiving and the frequency of changes in those medications. The Quarterly Psychiatric Review documentation contained a section identifying the timelines with which the prescribed medication could usually be expected to begin to exert therapeutic effects. Although this information was uniformly present for each medication the individual was prescribed, this was no longer clinically relevant in many cases, as the medications had been prescribed for several months or years. However, this information was important for assessing the efficacy of newly prescribed medications for which these timelines would be important to consider. CCSSLC Psychiatry and Psychology Progress Notes routinely carried forward several months of behavioral data. The determination of the efficacy of psychotropic medications would benefit from a longer overview of the chronological objective behavioral data. Data that presented the frequency of these behaviors over time in both a tabular and graphic format, including a summary of the contemporaneous medication changes and/or changes in the Behavioral Plan as they corresponded with changes in the frequency of the monitored behavior would greatly enhance the utility of this information. This database would then provide additional historical data points with which to make comparisons with current frequencies. This would enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be effective from an empirical perspective. Although the Psychiatry Department had devised a method for monitoring the frequency and intensity of the symptoms of the psychiatric disorder, they were dependent on the individual Psychologists to monitor the frequency of the other behaviors presented in the Psychiatric Clinic notes. These behaviors would primarily be those that were derived from the symptoms of the psychiatric disorder and/or those that were determined by both psychiatric and behavioral factors. Direct support professionals collected the actual raw data for these behaviors under the direction of the Psychologist assigned to the individual's residence. Concerns with regard to the accuracy and reliability of this data are discussed with regard to Section K.10.	

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		The final section of this provision related to the frequency with which the Psychiatrist reviewed individuals' prescribed psychotropic medication. The current review of a sample of the medical records indicated that Quarterly Reviews were performed as specified in this provision for all of the 18 individuals (100%). The evidence that the Psychiatrist had evaluated the individual at the time of the Quarterly Review was contained in the detailed Mental Status section of these documents. As discussed with regard to Section J.8, the Psychiatrist, a Psychiatric Nurse, a Psychiatric Assistant, the PCP, the QDDP, the Unit RN Case Manager, and a direct support professional usually attended the Psychiatric Clinics. The Psychiatry Department had made progress in relation to several of the requirements of this provision of the Settlement Agreement. Much of this progress was related to the Quarterly Review documentation for those individuals prescribed psychotropic medication. The finding of noncompliance for this provision is directly related to the lack of empirical evidence that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors required to establish the efficacy of each of the multiple medications prescribed.	
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 review of the Rights/Consents sections of the medical records for the sample of 18 individuals indicated five individuals (28%) had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for all of the 18 individuals in the sample (100%). At the time of the Monitoring Team's previous review, CCSSLC had implemented a number of measures to improve the risk-benefit analysis, as well as the quality of the information provided to the guardian or Facility Director regarding the possible side effects of the proposed medication. Specifically, the more generic material referred to in the Monitoring Team's earlier reports had been replaced with material from Micromedex, which is a nationally respected source of pharmacological information. In addition, the Facility was implementing an initiative to replace the practice of obtaining consents and Human Rights Committee approval for all of the individuals' psychotropic medication as a package with a process of obtaining consent for each medication as a separate entity. This change in the consent process was also mirrored in the Human Rights review process, in that the Human Rights approval process now addressed each medication as a separate entity. These processes had now been fully implemented for several months.	Noncompliance

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		As noted with regard to Section J.10, the current review found an improved discussion of the risk-versus-benefit considerations in 15 of the 18 records (83%) reviewed. The records of Individual #318, Individual #172, and Individual #238 contained risk-versus-benefit discussions, which were adversely affected by the number of psychotropic medications prescribed and the number of changes made in those medications. These factors also adversely affected the determination of efficacy of these medications, as discussed with regard to Section J.13. These deficits in the risk-versus-benefit determination made it difficult for a guardian to render a truly informed opinion. An important component of the Facility's plan to address these issues also involved a change to the consent process. Rather than having the individuals' Psychologist obtain the consent from the guardian, the Nurse in the residence would secure the consent. The communication between the nurse and the guardian was primarily written, unless verbal consent was requested by the guardian and/or was required to implement the medication on an urgent basis. However, the Psychiatrist and the other members of the Psychiatry Department, including the Psychiatric Nurses and the Psychiatric Assistants, all contributed to the information presented to the person providing consent. The Consulting Psychiatrist did not have any direct, written, or verbal contact with the guardian unless it was requested, or in the event that the guardian attended the Psychiatry Clinics, which was a relatively rare occurrence. The consents supplied by the Facility's Director for those individuals who did not have guardians were via written communication, unless the Facility Director had specific questions for the Psychiatric Team. The finding of noncompliance for this provision of the Settlement Agreement was related to the continuing deficits in the risk-versus-benefit discussions, although definite improvements had been noted with this process. The remaining deficits were primarily found in the records of those individuals who were prescribed larger numbers of psychotropic medication and had experienced more changes in those medications.	
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 Monitoring Team's initial reports identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist for individuals both disciplines followed. In response to these observations, the Psychiatry Department had developed a system intended to enhance the communication between the two disciplines. This system, facilitated by the Psychiatric Nurses and the Psychiatry Assistants, was designed to ensure that the Psychiatrist reviewed any recent neurological consultations and documented this review during the next Quarterly Psychiatric Clinic for that individual. Furthermore, the Neurologist was made aware of the individual's psychotropic medication, as well as recent changes in those medications, prior to the next scheduled neurological consultation. This process had now been fully operational for three review cycles.	Noncompliance

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		In order to assess the efficacy of this process, the neurology section of the records of the 18 individuals in the review sample were requested. Review of this documentation indicated that the Consulting Neurologist had only seen one individual (6%) within the last 12 months, and that was Individual #47. Reference to the most recent Neurology Consult was located in the Psychiatric Clinic Notes for this individual (100%). The most recent Neurology Notes also contained a reference to the psychiatric medications. In order to increase the size of this sample to make the review more reliable, eight individuals were chosen from the spreadsheet that the Facility maintained to track the occurrence of Neurology Consults for the individuals also prescribed psychotropic medication. To assess the documentation from both Departments, only those individuals who the Neurologist had seen recently and for whom enough time had elapsed that they should also have been reviewed in a subsequent Quarterly Psychiatric Review were reviewed. The eight individuals selected, the date of the Neurology Consultation, and the following Psychiatric Review dates were as follows:	

Individual	Date of Neurological Consultation	Date of Psychiatric Review
Individual #26	2/2/13	2/12/13
Individual #184	2/2/13	2/12/13
Individual #297	2/13/13	2/12/13
Individual #55	2/2/13	2/12/13
Individual #153	2/1/13	2/19/13
Individual #60	2/2/13	2/12/13
Individual #136	2/2/13	2/19/13
Individual #141	2/2/13	2/19/13

The documentation confirmed that the Neurology Consultation Notes contained the relevant information concerning the individual's psychiatric treatment for six of the eight individuals listed above (75%). The records of the two individuals that did not contain this information were those of Individual #184 and Individual #55, which contained no mention of their psychiatric status in the Neurology Note. The Neurology Consultation was both acknowledged and briefly summarized in the corresponding Psychiatric Review Note for all of the additional eight individuals (100%).

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		The extent of these discussions varied according to the context of the individual's clinical status. For example, if there had been an increase in the frequency of the individual's seizures, the Neurology Consultation Note and the following Quarterly Psychiatric Review documentation would be more extensive than it would have been if the individual was stable from both a neurological and psychiatric standpoint. The Facility had not carried out a formal assessment to determine the amount of Neurology Consultation time that would be needed to address the needs of CCSSLC. However, the Consulting Neurologist had the capacity to alter the frequency of his visits, if more clinical time was required. This did not appear to be a problem from the perspective of ensuring adequate coordination between the Neurology and Psychiatry Consultants. The finding of substantial compliance could not be carried forward from the previous review. The current finding of noncompliance is based on the finding that the Neurology Note contained adequate reference to the individual's psychiatric status in only seven of the nine (one from the sample, plus the additional eight described above) individual records reviewed (78%). The most recent Neurology Consultation that appeared in the subsequent Psychiatric Review Note provided a succinct overview of the corresponding Neurological Consultation. The other Neurology Notes alluded to the psychiatric aspects of the individuals' treatment. Given the past success that CCSSLC has had with this system, the Facility should conduct a careful analysis to determine why this lapse in documentation had occurred resulting in loss of a substantial compliance rating.	

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

1. CCSSLC should ensure that all of the sections of their chemical restraint documentation are completed in an adequate manner. The staff members at the Facility who complete the chemical restraint documentation should receive the necessary instructions to complete the documentation in a manner that describes the events that precipitated the individual's behavior and led to the need for chemical restraint. (Section J.3)
2. The procedures and individualized programs that have been developed and implemented to decrease the reliance on psychotropic medication for pre-treatment sedation of individuals for medical and dental procedures should be fully implemented, and revised as needed. (Section J.4)
3. The Facility should expand the initiative to develop Desensitization Plans for medical procedures/appointments. (Section J.4)
4. The data related to the status of the Desensitization Plans for dental and/or medical procedures would be more comprehensible and useful if it was consolidated into a master spreadsheet that was continuously updated. (Section J.4)
5. The Facility should specifically track information that identifies those individuals for whom the implementation of a behavioral Desensitization Plan or other strategies resulted in their no longer requiring pharmacological pre-treatment sedation for dental or medical procedures, or a decrease in the use of this medication. (Section J.4)
6. The Psychiatry Department should ensure annual updates of the overdue CPEs are completed and allocate sufficient psychiatric time to fulfill this goal. (Section J.6)

7. The Facility should expand its initiative to have a member of the Psychiatry Department attend the ISP meetings for individuals prescribed psychotropic medication, unless the team has provided sufficient justification a member of the Psychiatric Department not participating. (Sections J.8 and J.9)
8. Additional information concerning psychiatric medication and the related Treatment Plan should be included in the individual's ISP or ISPA documentation. This documentation should state explicitly whether or not the use of psychotropic medication for the individual: a) represents the least intrusive and most positive intervention; b) whether the individual will be best served primarily through behavioral, pharmacological, or other interventions; and c) identify non-pharmacological treatments and supports being used to address the signs and symptoms of the disorder. The deliberations and evidence that led the IDT to these conclusions should be explicitly stated, rather than a simple statement/opinion that these criteria have been met. In addition, the ISP action plans should include measurable objectives to ensure the collection of data necessary to evaluate the efficacy of any given medication. (Sections J.8, J.9 and J.10)
9. The risk-versus-benefit analysis contained in the documentation generated by the Psychiatry Department also should appear in other sections of the individual's record where applicable, including the PBSP, HRC, and ISP documentation. (Sections J.8, J.9, J.10 and J.14)
10. CCSSLC should continue and increase their attempts to decrease the utilization of polypharmacy with psychotropic medications. (Section J.11)
11. The Facility should increase its efforts to provide adequate empirical data to support the efficacy of psychotropic medications that the individuals' teams have concluded are essential for the individuals' continued psychiatric stability. (Sections J.11 and J.13)
12. The Facility should conduct a careful analysis to determine why backsliding had occurred in the neurologist's review of psychiatric information for individuals that both treated. (Section J.15)
13. The Psychiatry Department should enlist the assistance of the Quality Assurance Department in developing larger samples for their self-assessment process. In addition, the number of raters should be expanded, and the increase in the number of Psychiatrists should facilitate this initiative. (Facility Self-Assessment)
14. The internal review processes should be further refined to include quality parameters in addition to completion rates, where appropriate. (Facility Self-Assessment)
15. The Facility should consider adding an analysis of the chemical restraint data to its internal self-assessment process for Section J. (Facility Self-Assessment)

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 Section K Presentation Book, developed by Judy Sutton, M.S., LPC, BCBA, Chief Psychologist; o Behavior Support Committee (BSC) and external peer review meeting minutes, as available, dated 10/1/12 through 2/27/13; o For Section K.4, Positive Behavior Support Plans (PBSP) and PBSP Monthly Progress Notes, for the last three months, as available, for: Individual #141, Individual #312, Individual #77, Individual #42, Individual #237, Individual #255, Individual #159, Individual #167, Individual #177, and Individual #263; o For Section K.4, Crisis Intervention Plans (CIP) and PBSP Monthly Progress Notes, for the last three months, as available, for: Individual #172; o For Section K.5, Comprehensive Psychological Assessments, as available, for: Individual #147, Individual #263, Individual #177, Individual #167, Individual #279, and Individual #159; o For Section K.6, Psychological Evaluations or Comprehensive Psychological Assessments, and Inventory for Client and Agency Planning (ICAP), as available, for: Individual #255, Individual #172, Individual #147, Individual #263, Individual #295, Individual #177, Individual #167, Individual #279, Individual #109, Individual #159, Individual #252, Individual #23, Individual #237, Individual #359, Individual #68, Individual #201, Individual #42, Individual #77, Individual #312, and Individual #141; o For Section K.7, Psychological Assessments or Comprehensive Psychological Assessments, as available, for: Individual #39, Individual #59, Individual #98, Individual #115, and Individual #338; o For Section K.8, Counseling Treatment Plans, Weekly/Monthly Counseling Notes, Summary Listings of Treatment Goals, and PBSP Monthly Progress Notes (for three months), as provided, for: Individual #140, Individual #325, Individual #7, Individual #246, Individual #357, Individual #94, Individual #275, Individual #318, Individual #46, Individual #55, Individual #297, Individual #61, Individual #118, Individual #26, Individual #14, Individual #300, Individual #172, Individual #191, Individual #169, Individual #109, and Individual #218; o CCSSLC Positive Behavior Support Plans (i.e., summary of consent date, approved by BSC date, approved by HRC date, training roster date, and implementation date), not dated; o For Section K.9, Positive Behavior Support Plans for: Individual #147, Individual #77, Individual #42, Individual #159, Individual #167, and Individual #295; o For Section K.9, onsite chart review of consents related to PBSPs, as available for: Individual #38, Individual #218, Individual #159, Individual #153, Individual #307, Individual #225, Individual #368, and Individual #315; and o For Section K.10, Positive Behavior Support Plans and PBSP Monthly Progress Notes, for

	the last three months, as available, for: Individual #141, Individual #312, Individual #77, Individual #42, Individual #237, Individual #255, Individual #159, Individual #167, Individual #177, and Individual #263. ▪ **Interviews and Meetings with**: o Section K review with Judy Sutton, M.S., LPC, BCBA, Chief Psychologist on 4/1/13 and 4/2/13; o Meeting with Kristina Sheets, Director of Residential Programming, on 4/3/13; and, o Meeting with QA/QI and Section K Program Compliance Monitors, including Judy Sutton, M.S., LPC, BCBA, Chief Psychologist and Karen Ryder, QA/Program Compliance Monitor, on 4/4/13. ▪ **Observations Conducted**: o Observation and discussion at the Restrictive Practices Committee meeting, on 4/1/13; o Observation and discussion at the Psychology Department meeting, on 4/2/13; o Observation and discussion at the BSC follow-up meeting, on 4/2/13; o Observation and discussion at the Skill Acquisition Committee meeting, on 4/2/13; o Observation and discussion at the BSC Meeting, on 4/3/13; o Observation and discussion at the Vocational Department meeting, on 4/4/13; o Observation of PBSP training at Porpoise, on 4/4/13; o Observation of Skill Plan Integrity checks at Ribbonfish 1 (524A) and the Outer Reef, on 4/4/13; o Onsite direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 522A (Kingfish 1), on 4/1/13; ▪ Apartment 522B (Kingfish 2), on 4/1/13; ▪ Apartment 522 C (Kingfish 3), on 4/1/13; ▪ Apartment 522D (Kingfish 4), on 4/1/13; ▪ Apartment 524A (Ribbonfish 1), on 4/2/13 and 4/4/13; ▪ Apartment 524B (Ribbonfish 2), on 4/2/13; ▪ Apartment 524C (Ribbonfish 3), on 4/2/13 and 4/3/13; ▪ Apartment 524D (Ribbonfish 4), on 4/2/13 and 4/3/13; ▪ Apartment 514 (Dolphin), on 4/3/13; ▪ Apartment 518 (Porpoise), on 4/3/13; ▪ Apartment 515 (Sea Horse), on 4/3/13; and ▪ Outer Reef, on 4/4/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section K, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the

	monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the CCSSLC PBSP Peer Review rubric as well as the CCSSLC Psychology Evaluation/FBA Comprehensive Peer review rubric. A few examples of completed rubrics as well as limited data on compliance across items (i.e., some of the items for each rubric) and residences (i.e., 522C and 524D) were provided for review. Verbal reports at the time of the Monitoring Team's visit indicated that approximately two monitoring tools per month were completed since October 2012, with four completed in February and March 2013 (only February data was provided for review). Discussions during the onsite visit reflected potential future efforts to expand the use of these tools and, consequently, it appeared that future changes related to the monitoring tool were likely. ▪ Used some other relevant data sources. o The current Self-Assessment also contained other types of data from available sources. This included data obtained from BCBA certifications, BSC attendance rosters and meeting minutes, external peer review meeting minutes, random samples of documentation (e.g., PBSP progress notes, psychological assessments, comprehensive psychological assessments, counseling progress notes, etc.), as well as information from the behavioral services database, including consent and approval dates (for psychology assessments, PBSPs, CIPs, etc.), and the competency-based training database. ▪ The Facility consistently presented findings based on specific, measurable indicators. ▪ The Facility measured the quality as well as presence of some items. ▪ The Facility rated itself as being in compliance with Sections K.2 and K.5. Only the Facility's rating on Section K.2 was consistent with the Monitoring Team's current findings.
	Summary of Monitor's Assessment: Progress was noted in most sections of Section K of the Settlement Agreement. However, concerns remained in most areas as well. Progress was noted within Behavioral Health Services as two psychologists passed the BCBA exam and were now certified. However, several staff had decided not to pursue certification. The diversity of BSC membership, with regard to internal peer review, had become less heterogeneous over time. Progress, however, in the provision of external peer review was noted. Progress was evident in the completion of standardized intellectual assessments and scales of adaptive behavior in an effort to ensure that psychological assessments were updated at least every five years. However, concerns regarding the lack of clarity regarding when some of these assessments were completed and issues relative to their timely approval were noted. In addition, continued completion of Comprehensive Psychological Evaluations was noted for increasing numbers of individuals with PBSPs. Progress was noted in the area of PBSPs with the development of a new and improved format that was currently being piloted. Active efforts were noted with regard to writing PBSPs so that they could be understood and implemented by direct support professionals. Limited progress was noted in the timely

	completion of psychological assessments for newly admitted individuals, as well as in the provision of counseling supports to individuals referred for counseling. Continued progress in the use of a standardized PBSP monthly progress note was evidenced. This included continued improvement in the area of data display and ongoing PBSP monitoring, including continued inter-observer agreement checks on behavioral data. However, concerns were noted with the timeliness of monthly note completion. Lastly, some progress was noted in competency-based training. However, the provision of adequate training across the Facility for the behavioral programming of most individuals remained inadequate. As currently designed, the nature of training continued to appear resource-dependent and inefficient.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Since the Monitoring Team's last visit, Psychologists in the Behavioral Health Services Department continued to make progress in obtaining necessary educational competencies and supervision needed to demonstrate competency within Applied Behavior Analysis. At the Monitoring Team's previous visit, a total of four psychologists had completed all of the required coursework. Since the Monitoring Team's last visit, two staff registered for and successfully passed the BCBA exam. Consequently, at the time of the current visit, there were three staff members (out of a total of 16) currently in the Behavioral Health Services Department, including the Director, who were currently BCBAs. Based on current verbal reports, the Director did not carry a caseload. Therefore, there were only two BCBAs currently writing PBSPs. At the time of the Monitoring Team's visit, there were seven psychologists who were currently enrolled in coursework and four staff currently receiving required supervision. According to verbal reports, of the 12 current psychologists not yet certified, nine had completed at least one or more of the required courses. One additional psychologist not yet enrolled in any classes was recently hired. In addition, reports indicated that three psychologists had finished their required supervision. However, at this time, it appeared that three psychologists recently had chosen not to purse certification. According to the Director of Behavioral Health Services, remediation plans for these staff included spending fours hours a week (i.e., the same amount of time allocated to coursework) supporting residential programs in the Atlantic unit. Verbal reports and documentation indicated that the same two contracted BCBA consultants continued to provide required supervision. The Director of Behavioral Health Services and contracted supervisors should continue to ensure adequate	Noncompliance

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		adherence to the Behavior Analyst Certification Board supervision guidelines and policies, including the completion of supervisory signature forms. This provision continues to be rated as being in noncompliance because the professionals in the Behavioral Services 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. Currently, only three members of the 14 Behavioral Health Services Department were BCBAs. 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.	As previously reported, Judy Sutton, MA, LPC, BCBA was hired as the Director of Behavioral Health Services. Ms. Sutton had a Master's degree in Psychology, was a Licensed Professional Counselor in Texas, and since 2009, had been a Board Certified Behavior Analyst. She had extensive experience supporting individuals with intellectual, mental, and physical disabilities, and had worked in the human services field since 1994. It appeared that the Director of Behavioral Health Services continued to maintain a consistent level of psychological care throughout the Facility based on the continued progress noted in the provision of psychological services observed since the last visit. Based on this finding, the Facility continued to be found in substantial compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Since the Monitoring Team's last visit, some progress was noted in the area of internal and external peer review within Psychological and Behavioral Services. As previously described, internal peer review of behavioral health services was provided through the Behavior Support Committee. In the past, this committee was scheduled to meet twice a week, and the Monitoring Team's previous reports noted that the BSC met for 61%, 100%, 77%, and 89% of the time for the time periods of June to December 2010, January to May 2011, July to November 2011, and December 2011 to June 2012, respectively. It was also previously noted that establishing estimates of BSC meeting adherence was challenging as the schedule changed over time. Indeed, the BSC schedule changed from meeting twice a week to once a week in March 2012, and then back to twice a week in August through November 2012. And, more recently, the meeting returned to once a week in December 2012 through February 2013. Consequently, estimates of schedule adherence continue to be "approximations." In addition, "paper reviews" were noted in previous documentation as well. These appeared to be times where reviews of documentation occurred, but without the entire committee in attendance or participating. Similar findings were found within the current review. That is, based on currently provided BSC meeting minutes (between 10/1/12 and 2/27/13), it	Noncompliance

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		appeared that the BSC met 63% of the time. Based on this documentation, it appeared the BSC was scheduled to meet approximately 30 times during this time period. That is, it was believed that BSC was scheduled twice a week in October 2012 and November and once a week in December 2012, January 2013 and February 2013. During this time period, it was also observed that "paper reviews" were conducted six (20%) times, four (13%) meetings were cancelled, and no evidence was provided to confirm that one meeting (on 10/2/12) was held as expected. It should be noted that the Monitoring Team assumed 12/26/12 would not have been scheduled given the holiday the day prior. Although it appeared that multiple meetings per week were possible, the Monitoring Team only expected the BSC to meet once weekly. Consequently, given the time period of 10/1/12 through 2/27/13, it appeared that the BSC should have met approximately 21 weeks (not including 12/24/12 to 12/28/12). Overall, it appeared that the full BSC met at least once weekly in 17 (81%) out of 21 possible weeks. That is, it appeared that the BSC meeting(s) was either cancelled or a "paper review" was held (without the full committee) in four of these weeks (i.e., 10/8/12 to 10/12/12, 11/19/12 to 11/23/12, 12/17/12 to 12/21/12, and 2/11/13 to 2/15/13). As previously reported, CCSSLC policy recommended that the BSC have a diverse membership. A consistent finding over the Monitoring Team's last few reports, however, was a noted decline in the diversity of membership. This included decreasing representation from psychiatry, nursing, habilitation therapies, and administration. Improvement, however, had been noted in the attendance of contracted BCBAs, community-based counselors, psychology assistants, and the Director of Behavioral Health Services. Unfortunately, based on currently provided evidence, this diminishing trend continued to be observed. Based on review of BSC meeting minutes over the last six months (i.e., meeting minutes from 10/1/12 through 2/27/13), adequate attendance was only evident by behavioral health services staff members. More specifically, attendance above 75% was consistently found for the Director, Clinical Psychologist, Psychologists, and Psychology Assistants. Poor attendance at BSC meetings was found for all other attendees, including nursing (40%), psychiatry (5%), administration (25%), QA/QI (25%), external BCBAs (30%) and the contracted counselor (5%). Interestingly, review of BSC meeting minutes evidenced a substantial increase in the diversity of attendance in the month of January 2013. Indeed, the above data for administration and psychiatry was solely based on participation in BSC in January 2013. It was unclear to the Monitoring Team what precipitated such a substantial improvement in attendance of diverse members for only a single month. Currently, according to verbal reports from the Director of Behavioral Health Services, the format and composition of internal peer review had changed. That is, the BSC only	

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		met once a week (started in December 2012). In addition, a BSC follow-up meeting was scheduled once a week as well. However, the BSC follow-up meeting appeared to include only a small number of individuals (e.g., Associate Psychologist, supervising Psychologist V, and the Director) and included a targeted review of a few select documents. This meeting appeared to be designed to provide in-depth individual feedback and not overall approval as typically obtained through the BSC. Consequently, the Monitoring Team viewed the follow-up meeting as a supplement to, not a replacement of, the BSC. Verbal reports also indicated that the composition of the BSC had changed. That is, the Director of Behavioral Health Services indicated that Facility staff external to the Behavioral Services Department (i.e., nursing, psychiatry, speech language pathologists, administration, etc.) would no longer be required to attend the BSC meeting. This change appeared to occur in April 2012. Verbal reports indicated that QA/QI as well as external meaningful contributors (e.g., contracted community-based BCBAs and counselors, etc.) would still be welcome when their schedules permit attendance. The provided Section K Action Plan (dated 3/4/12) indicated that the identification of individuals required to attend BSC would be noted in the revised policy. At the current time, the revision of the policy was still noted to be "in process." According to the Monitoring Team's previous reports, external peer review was initiated in January 2012 and started with the inclusion of professionals from one other Texas State facility (i.e., Abilene State Supported Living Center). However, over time, additional State Supported Living Centers (i.e., at Austin and Lubbock) were included. The Monitoring Team's previous review of this progress, however, noted inconsistent and inadequate interaction between these external reviewers. Consequently, the status of the external peer review was judged to be inadequate following the Monitoring Team's previous review. Currently, provided documentation (monthly External Peer Review meeting minutes, dated May 2012 through January 2013) was reviewed to examine the nature of the external peer review process. It appeared that one meeting was held each month during this time period. However, on one occasion (i.e., 6/15/12), only the behavioral services staff from Corpus Christi appeared to be present at the meeting. Overall, it appeared that two or more State Facilities were involved in peer review process in eight (89%) of the monthly meetings. The purpose of the external review process is for independent experts to review behavioral programming and provide feedback and recommendations. However, this process appeared somewhat limited by the non-availability of programs presented for review. More specifically, a case or concern was presented from Corpus Christi and reviewed by external peer reviewers at six (67%) of the meetings. It was unclear why the Facility did not take the opportunity for expert case review at three of the scheduled meetings (i.e., on 5/11/12, 7/13/12, and 12/14/12). The expectation is that at least one program from the Facility will be reviewed as part of external peer	

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		review each month. CCSSLC had not met this requirement. When reviews were conducted, they appeared to be sufficient case reviews. Lastly, once the ongoing evolution of the internal and external peer review process is finalized, the Facility will need to ensure that current procedures are reflected in policy. The Facility continued to be in noncompliance with this provision, because of the inadequate adherence to the schedule, inadequate attendance of professionals demonstrably competent in applied behavior analysis, the inconsistent case review by professionals external to CCSSLC, and the lack of guidelines regarding internal and external peer review in current policies.	
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.	Since the last review, progress continued to be evident in the area of data collection. Although methods of monitoring showed progress, concerns about the adequacy of data collection remained. In an attempt to examine the quality of current data collection and assess progress toward compliance within this provision of the Settlement Agreement, a sample of 10 individuals who had an ISP meeting within the last six months (between 10/1/12 and 03/31/13) and who also had a PBSP were selected and reviewed. Based on provided summary data ("CCSSLC Positive Behavior Support Plans," undated), this sample reflected 8% of the total number (N=125) of active PBSPs. This review included the examination of the current PBSPs as well as PBSP monthly notes from the last three months, as available. Review of provided documentation indicated: ▪ All 10 (100%) had monthly progress notes completed across the last three consecutive months (December, January, and February); ▪ At least one target behavior and at least one replacement behavior were displayed in monthly progress notes for 10 (100%) of the individuals sampled: ▪ Target and replacement behaviors were consistent across the PBSP and monthly progress notes for eight (80%) of the individuals sampled. The exceptions included Individual #77 and Individual #167; ▪ Graphic displays of one or more target behavior(s) were evident in 10 (100%) of the individuals sampled; ▪ Graphic displays of one or more replacement behavior(s) were evident in 10 (100%) of the individuals sampled; ▪ Medications were displayed in graphic and table format for six (60%) and two (20%) individuals, respectively. Medication was not displayed in any format for Individual #167 and Individual #237; ▪ Inter-observer agreement (IOA) probes were reported in one or more of the monthly notes for nine (90%) of the individuals sampled. However, concerns were noted with how this data was presented. For example, even though probes	Noncompliance

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		were discussed, data reported regarding the IOA probes appeared complete for only six (60%) of the individual sampled; ▪ Monthly notes appeared to be completed in a timely fashion for one (10%) of the individuals sampled. This included the note for Individual #167. The remaining monthly notes appeared to be completed during the month the report was targeting or over four weeks (or more) after the particular month the progress note covered; ▪ Monthly notes appeared to contain appropriate data in eight (80%) of the individuals sampled. The remaining monthly notes included data from upcoming months for Individual #42 (January and February 2013 data reported in the December 2012 note, as well as February data report in the January note) and Individual #159 (February data in the January note); ▪ Monthly notes appeared to be descriptive, timely, and offered clinical insight beyond the graphed data in the progress notes of five (50%) of the individuals sampled. More specifically, the summary and/or implementation sections appeared very similar or, at times identical, across months for Individual #255, Individual #177, Individual #312, and Individual #42; and ▪ Data related to competency-based training was found for one (10%) of the individuals sampled (i.e., Individual #159). In general, it appeared that the majority of monthly notes used graphs to effectively display target and replacement behaviors. Medications were also displayed using both graphic and table format. It should be noted that minor concerns were noted with the graphic displays and these are discussed in greater detail with regard to Section K.10 of the Settlement Agreement. One of the primary concerns noted above included the timeliness of the completion of monthly notes. More specifically, most notes did not appear to be completed within four weeks of the targeted month. Or, notes appeared to be completed in the middle of the month in which they were reviewing (e.g., February note, dated 2/15/13, for Individual #177, and December, January, February notes, dated 12/4/12, 1/22/13, and 2/5/13, for Individual #237). In many cases, information provided in the summary, implementation, and/or recommendation sections appeared "cut and pasted" across months. In some cases, it was obvious that information was simply copied and re-used across reports perhaps due to the fact that the reports were completed months after the fact (e.g., Individual #42). In addition, although IOA probes were discussed, several notes did not provide actual IOA data, information on when the IOA probes were conducted, the specific response targeted, and/or the actual IOA estimate generated (i.e., notes for Individual #77, Individual #159, Individual #167, and Individual #177). These findings are discussed in greater detail with regard to Section K.10 of the Settlement Agreement. As previously reported with regard to Section K.9 of the Settlement Agreement, objective	

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		criteria for the revision or discontinuation of PBSPs was lacking in most of the plans reviewed. More specifically, objective and measureable criteria for revision were found in none (0%) of the plans reviewed. Relatedly, objective and measurable criteria for discontinuation were found in two (33%) of the plans reviewed. These included the plans for Individual #295 and Individual #42. Of the sampled PBSPs reviewed, zero (0%) rationales indicated that the plans were re-evaluated and/or revised due to the lack of progress or changes in maladaptive behavior as evidenced by collected data (i.e., reflecting data-based decision making). Most of the plans continued to offer a general statement regarding the need to address or manage target behaviors, potentially learn new skills (e.g., communication), become more independent, and/or support a successful community placement. Consequently, it was not evident from sampled PBSPs that any had been revised due to its ineffectiveness or change in the individual's functioning or his/her challenging behavior. However, of the PBSP monthly notes reviewed for the 10 sampled individuals (as described above), recommendations in one individual's notes indicated that the PBSP was being revised to due to her lack of progress given the previous PBSP. According to provided documentation ("CCSSLC: Individuals with Crisis Intervention Plans," dated 3/8/13), 10 individuals currently had Crisis Intervention Plans. In an attempt to examine the quality of current data collection with regard to CIPs, one individual (i.e., Individual #172) who had an ISP meeting within the last six months (between 10/1/12 and 03/31/13) and who also had a CIP was sampled and provided documentation was reviewed. Based on provided summary data, this sample reflected 10% of the total number (N=10) of current CIPs. This review included the examination of the current CIP as well as PBSP monthly notes from the last three months, as available. Overall, based on provided documentation, the CPI had been updated within the past year and graphed restraint data was found in the PBSP monthly notes for Individual #172. Indeed, the graph utilized in the December 2012 monthly note was well designed. Data displayed included frequency and duration of physical restraint as well as the frequency of chemical restraint. The monthly notes also included a description of the restraints within the context of the note as well. The Facility continued to be in noncompliance with this provision due to the limitations with the timely completion and content of monthly reviews and use of the data to review the need for changes to the PBSPs as described above.	
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	Progress continued to be observed in the completion of standardized tests of intelligence and tests of adaptive behavior. In addition, the increasing use of a new format, the "Comprehensive Psychological Evaluation," continued to be evident. As presented with regard to Section K.6 of the Settlement Agreement, of the 20 sampled	Noncompliance

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	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.	psychological assessments reviewed, 20 (100%) were updated within the last 12 months. In addition, psychological evaluations indicated that 18 (90%) of the sampled individuals had an ICAP evaluation completed within the last three years. In addition, as discussed below with regard to Section K.6, concerns were noted with regard to the completion of psychological assessments prior to the ISP meeting. Closer examination revealed that 20 (100%) contained results of previously completed standardized tests of intelligence, and 17 (85%) of these were completed within the past five years. Tests of adaptive function were reported in 20 (100%) of the current psychological assessments, and 18 (90%) of these tests were completed within the past five years. Indeed, there was a substantial improvement in the number of intellectual assessments and tests of adaptive functioning completed since the Monitoring Team's previous visit. As observed during the Monitoring Team's previous reviews, in addition to the psychological assessment discussed above, 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 Settlement Agreement. As described in the Monitoring Team's previous review, a new "comprehensive psychological evaluation" format had been developed and implemented. Documentation provided at that time evidenced that approximately 13 evaluations had been completed using this new format. Currently, according to provided documentation ("CCSSLC Comprehensive Psychological Assessment with an FBA," not dated), it appeared that approximately 55 comprehensive psychological assessments had been competed. Review also revealed that approximately 21 of these had been completed within the last six months (between 10/1/12 and 3/31/13). Based on provided documentation, it appeared that comprehensive psychological assessments had been completed for approximately 44% of those individuals (N=125) with PBSPs. In an attempt to more closely examine the quality of current functional behavioral assessments and, consequently, assess recent progress toward compliance within this provision of the Settlement Agreement, a sample of six individuals who had an ISP meeting within the last six months and who also had a comprehensive psychological assessment were selected and reviewed. This sample reflected approximately 11% of the total number of comprehensive psychological assessments currently in place and 29% of those completed within the last six months. Review of the six sampled comprehensive psychological assessments indicated that five (83%) contained a	

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		functional behavioral assessment using accepted processes or instruments. The exception was the comprehensive psychological assessment for Individual #147 that did not include any standard methods typically included within a functional behavior assessment and as compared to the other sampled reports reviewed. Of these five assessments, five (100%) utilized both indirect and direct measures, contained content that investigated whether or not the behaviors were learned or biological, presented potential setting events or establishing operations, antecedents and consequences, and described potential functions relevant to problematic behavior. It appeared that authors of the assessments, at times, could have discriminated more clearly between establishing operations and identified antecedents (e.g., Individual #159 and Individual #279). Lastly, of the five assessments, all (100%) identified functionally equivalent replacement behaviors. Overall, for most of the reports reviewed above, assessments appeared to be very comprehensive and detailed and included information necessary for a typical psychological evaluation as well as data required within a functional behavior assessment. The relevant medical, psychiatric, psychosocial, and other content provided appeared to offer information that was likely to facilitate a better understanding of the individual and their status and current responding. Information regarding standardized testing (e.g., intellectual and adaptive measures), communication, strengths, and preferences, as well as data derived from current and previous indirect and direct assessments all provided information valuable to effective programming. This finding was consistent with those reported in the Monitoring Team's previous report. Overall, these evaluations continued to offer utility to the IDT when planning treatment and interventions. Concerns remained, however, with regard to the length of these reports. Consequently, where appropriate, the Facility should consider summarizing collected raw data when possible and reducing redundancy of information across reports. For example, specific behavior interventions, behavioral objectives, and data were included, but this information is found in other reports and it might be more efficient to identify one document where the information would be included. Additionally, raw data could be summarized in the assessment and stored for further examination, if necessary. In addition, the rationales for these assessments should reflect revision due to the lack of progress, when appropriate. The Facility should remain vigilant with regard to striking a balance between the breadth and depth of the information provided and ensuring that the findings are summarized and integrated into current interventions. The Facility reported continued use of the Psychological Evaluation/FBS Comprehensive Peer Review rubric that was described in the Monitoring Team's previous report. This rubric included 41 items and was scored using a 0-2 Likert scale. Verbal reports	

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		indicated that this comprehensive rubric continued to be used by psychologists when completing evaluations as well as peer reviewers when critically examining the document. Results described above appeared to demonstrate the effectiveness of this self-monitoring and peer review tool. The Facility indicated that the use of this rubric would continue with possible improvement/revision in the future. In summary, a significant improvement in sampled comprehensive psychological assessments was observed. Although this improvement was notable, the majority of individuals with PBSPs had not yet had comprehensive psychological assessments completed. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	Progress continued to be made in the area of psychological assessments. As described in the Monitoring Team's previous reports, the Facility's expectation that each individual residing at CCSSLC have a current psychological evaluation had remained unchanged. This required that a psychological assessment be completed, updated, and/or reviewed at least annually for each individual served. This expectation included reviewing results 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, psychological assessments and ICAP documentation from a sample of 20 individuals was examined. This sample was selected from those individuals that had had an ISP meeting within the past six months. Given the current census of 246 individuals at the time of the current visit, this sample reflected approximately 8% of the total number of psychological assessments. Consequently, psychological assessments or comprehensive psychological assessments, as provided, were reviewed for each individual sampled. Alternatively, provided summary documentation (i.e., "CCSSLC psychological evaluations") indicated that approximately 79 psychological evaluations (including those with comprehensive evaluations) had been completed in the last six months (between 10/1/12 and 3/31/13). Consequently, since 17 of the individuals sampled had psychological assessments updated within this time period, the current sample more closely reflected approximately 22% of those most recently completed. As previously presented with regard to Section K.5 of the Settlement Agreement, of the sampled assessments reviewed, 20 (100%) were updated within the last 12 months. It should be noted, however, that the Monitoring Team was unclear what date (as indicated	Noncompliance

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		on the assessment) represented when the plan was "complete." That is, some plans contained multiple dates, including one or more signature dates, which often did not match the "assessment date" as indicated on page one of the assessment. Indeed, of those sampled, 14 (70%) contained multiple dates making it challenging for the Monitoring Team to determine when the assessment was completed. This determination was necessary to examine whether or not the assessment was completed prior to the ISP meeting. Currently, when comparing the recorded "assessment date" to the ISP date, it appeared that 17 (85%) assessments were completed prior to the ISP. The exceptions were individuals with assessments completed after the ISP (i.e., Individual #167 and Individual #159) and an assessment that was not dated (i.e., Individual #42). However, when comparing the signature date on the psychological assessment to the ISP date, it appeared that seven (35%) assessments were completed prior to the ISP. The exceptions were the assessments for Individual 172, Individual #147, Individual #263, Individual #295, Individual #167, Individual #279, Individual #109, Individual #159, Individual #237, Individual #201, Individual #42, Individual #77, and Individual #141. The Monitoring Team will need to establish which indicator (i.e., the recorded "assessment date" or signature date) most accurately reflects the actual completion date of the assessment during the next visit. Provided documentation indicated that of the assessments reviewed, 18 (90%) of the sampled individuals had an ICAP evaluation completed within the last three years. The exceptions included the assessment with an ICAP completion date that exceeded three years (i.e., the ICAP for Individual #295 was completed on 2/10/09) and an assessment where no ICAP information was reported (Individual #237). In addition, typos or errors were found when comparing results on the ICAP with reported dates or scores in the assessments for Individual #263, Individual #295, Individual #177, Individual #167, and Individual #359. Of the psychological assessments reviewed, 20 (100%) contained results of previously completed standardized tests of intelligence. These assessments generally included the use of the Wechsler, Slosson, Toni, and/or Peabody tests. Overall, 17 (85%) of these intelligence tests were completed within the past five years. The exceptions included the assessments for Individual #237, where testing results of the Slosson were not dated, and the assessments for Individual #77 and Individual #295 that reported intelligence scores that were over ten years old. The progress in this area as noted in the Monitoring Team's previous report continued to be evident within the current sample. Tests of adaptive functioning (e.g., Vineland Adaptive Behavior Scales) were reported in 20 (100%) of the current psychological assessments. Overall, 18 (90%) of these tests of adaptive behavior were completed within the past five years, including 14 (78%) that were conducted within the past year. The exceptions, Individual #295 and Individual	

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		#237, reported scores from adaptive scales that were over ten years old. The current results evidenced considerable improvement compared to findings reported in the Monitoring Team's last report. Indeed, there was a noted improvement in both the number of intellectual tests as well as adaptive behavior assessments completed since the Monitoring Team's last visit. Overall, review of the sampled psychological assessments reflected variability in the template used for the evaluation. That is, 12 (60%) individuals had the previous psychological assessment format, while the remaining eight (40%) individuals had the more recently developed "comprehensive psychological assessment" format completed. As presented in the Monitoring Team's previous report, the comprehensive psychological assessment was the integration of the previous psychological assessment with the structural and functional behavior assessment (SFBA). Consequently, only those individuals with PBSPs require a SFBA or the comprehensive psychological assessment. Of the 20 individuals sampled, 15 appeared to currently have PBSPs. Of these 15 individuals with PBSPs, eight (53%) had the comprehensive psychological assessment completed. The Monitoring Team expected that more individuals with PBSPs would have the new format in the future. Indeed, improvement in completion rates was noted since the Monitoring Team's last visit. It should be noted that additional findings and implications associated with the use of this comprehensive psychological assessment format was discussed with regard to Section K.5. Because it was unclear if many of the sampled psychological assessments were completed in time to inform the ISP process and the fact that the Facility was still in the process of completing of the new comprehensive psychological assessments for the remaining individuals with PBSPs, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	Overall, progress was noted in the provision of psychological assessments for all CCSSLC residents. However, limited progress was noted in the timely completion of psychological assessments for individuals newly admitted to CCSSLC. To determine whether or not psychological assessments were completed, updated or reviewed as often as needed, documentation provided on 20 sampled individuals was examined. As presented with regard to Section K.6 of the Settlement Agreement, of the 20 sampled psychological assessments reviewed, 20 (100%) were updated within the last 12 months. However, as previously presented, a number of these assessments appeared to be completed after the ISP meeting and, consequently, the Monitoring Team questioned whether these assessments were readily available to effectively inform the ISP process. Specifically, as identified with regard to Section K.6, although it was often difficult to determine a completion date, when comparing the recorded "assessment	Noncompliance

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		date" to the ISP date, it appeared that 17 (85%) assessments were completed prior to the ISP. Examination of overall delinquency rates of psychological evaluations was not completed at the last Monitoring review due to questions about the fidelity of the Behavioral Health Services database (i.e., that it contained inaccurate and likely falsified data). However, recent reports from the Director indicated that the database was "restored" and the information in the database was accurate. At the time of the most recent onsite review, the Monitoring Team requested the recent summarized data of Psychological Evaluations and examined it to determine the number of outdated psychological evaluations. However, it was evident that the database might still be inaccurate. That is, dates on provided psychological assessments (i.e., actual copies) were compared to dates on provided summary listings (i.e., dates as recorded within the database) and only three (15%) of the current sample (as described in Section K.6 of the Settlement Agreement) had the same dates. Consequently, the Monitoring Team questioned the accuracy of the summary listing. Nonetheless, the provided summary data was used to estimate delinquency rates. That is, the Monitoring Team identified the number of psychological evaluations with dates of completion greater than 12 months from the time of the Monitoring Team's current visit. According to dates listed, it appeared that approximately 89 (36%) of the assessments, based on the census of 246, were outdated. It should be noted that this estimate was not consistent with the findings based on the sample reviewed for Section K.6 of the Settlement Agreement. In addition, when comparing the "evaluation date" (i.e., completion date) with the "approved by BSC" date for psychological evaluations, a number of assessments appeared delayed in getting approved. More specifically, it was found that approximately 21 (8%) of the psychological evaluations appeared to take four or more months to receive BSC approval. This four-month criterion was randomly picked, and with closer inspection, additional examples were found where receipt of BSC approval took even longer. For example, brief review revealed examples where approval took six (Individual #205 and Individual #304), seven (Individual #26 and Individual #339), eight (Individual #221), nine (Individual #53) and ten (Individual #379) months. The Monitoring Team believed that these delays were likely the consequence of efforts to improve the adequacy of these assessments, but the actual reason was unknown. As presented in the Monitoring Team's previous reports, the Behavioral Health Services Database allowed staff to track important completion, approval, and/or implementation dates of Psychological Evaluations, Structural Functional Behavioral Assessments, Positive Behavior Support Plans, Crisis Intervention Plans, and Desensitization Plans. The Monitoring Team's previous reports had noted concerns with increasing delinquency rates and, more recently, corruption of the database. Currently, the	

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		Monitoring Team was unsure of the accuracy of the information on summary listings provided for review. Once again, the Monitoring Team's ability to examine progress toward compliance with the Settlement Agreement was limited by concerns for the accuracy of the data. According to provided documentation, since the Monitoring Team's previous review, five individuals were admitted to CCSSLC, including: Individual #39, Individual #59, Individual #98, Individual #115, and Individual #338. Of these, only two (Individual #59 and Individual #338) had psychological assessments that were available for review. It should be noted that Individual #39, Individual #98, Individual #115 might have been admitted very recently (within the last month), although, specific admission dates were not requested. Of the two individuals with available psychological assessments, only Individual #59 appeared to have a psychological assessment completed and approved by BSC within 30 days of admittance. More specifically, the psychological assessment for Individual #59 appeared to be completed on 12/3/12 as well as reviewed and approved by BSC on 12/5/12. It was noted, however, that this assessment was revised (on 2/13/13), perhaps to include results of more recent intellectual testing (completed on 1/17/13). It was unclear to the Monitoring Team whether or not this recent revision was approved by the BSC. Although the psychological assessment for Individual #338 appeared to be completed within 30 days of admittance (on 11/12/12), the assessment was not reviewed and approved by BSC until 1/8/13. It should be noted that none of the psychological assessments were signed or dated by the authors. As a result of issues related to the availability of psychological assessments as well as the timeliness of their approval and the lack of confidence in the adequacy of current Behavioral Health Services database, the Facility remained out of compliance with this provision.	
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 with regard to the provision of services to individuals requiring psychological services other than PBSPs, including the way in which counseling treatment plans were developed and monitored. Consistent with the Monitoring Team's previous review, two community-based counselors continued to provide weekly counseling supports to individuals at the Facility. Currently, according to provided documentation, 21 individuals were identified as receiving (or referred for) counseling services during the last six months (i.e., 10/1/12 to 3/31/13). In response to requests for documentation, the Facility indicated that: "CCSSLC does not have formal counseling plans. We have included our summary sheet to include treatment goals and objectives, titled "Individual Contract Treatment Goals." These summary sheets were provided and reviewed. However, documents entitled "Counseling Treatment Plans" also were included in documentation provided by the	Noncompliance

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		Facility for five individuals (i.e., Individual #300, Individual #172, Individual #191, Individual #169, and Individual #109). Consequently, the Monitoring Team was unclear which documents reflected current practice by the Facility and consulting contracted counselors. For the current report, both of these documents were reviewed. Of these 21 individuals identified as receiving counseling services, five (24%) had a "counseling treatment plan" in place. The remaining individuals had a treatment goal and related objective as evidenced by information provided on the "Individual Contract Treatment Goals" summary. Overall, 19 (90%) individuals had one or more counseling objective(s) identified. The exceptions were Individual #218 and Individual #318. PBSP monthly notes were available for 15 individuals and current examination of these notes indicated that only four (27%) listed counseling related objectives. However, only one of these appeared consistent with previously identified treatment goals (i.e., on the "Individual Contract Treatment Goals" listing for Individual #46). And, of these with objectives, only one (Individual #46) provided data. The remaining three monthly notes contained either incomplete objectives (Individual #7 and Individual #94), or an objective that did not match the previously identified treatment objective (i.e., Individual #325). Out of the 15 individuals with PBSP monthly notes, data targeting counseling objectives were only included in the five (33%) monthly notes reviewed (i.e., Individual #275, Individual #46, Individual #55, Individual #297, and Individual #61). However, the data presented for Individual #275 was not current data. In addition, counseling notes were only evidenced for 16 (76%) of the individuals receiving counseling supports. Overall, review of this provision of the Settlement Agreement was challenging for the Monitoring Team due to the inconsistency across documentation as well as the lack of clarity with regard to the expected rigor of counseling treatment plans. In addition, information provided within PBSP monthly notes was often inconsistent with the expected counseling supports. For example, Individual #191 had a counseling treatment plan (dated 11/28/12) that identified a new counselor, yet the PBSP monthly notes referenced a previous counselor and their inadequate provision of counseling related data in the months of December 2012 and January 2013. In addition, information noted in PBSP monthly notes either did not even acknowledge the counseling supports in place (Individual #26 and Individual #118) or had inaccurate information about current supports (Individual #191). In addition, the Monitoring Team noted concern with the inclusion or lack of data within several of the PBSP monthly notes. That is, monthly notes (i.e., December 2012 and January 2013 for Individual #275) were missing months of counseling-related data and monthly notes (i.e., December 2012 and January 2013 for Individual #191) included data that, technically, had not yet occurred yet (i.e., February 2013 note). Similarly, concerns were noted about monthly notes that were signed and dated prior to the end of the month (December 2012 and February 2013 for Individual #169 and Individual #172), or monthly reports that were signed and dated months late	

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		(e.g., December 2012 and January 2013 that were signed/dated in April 2013 for Individual #109, as well as December 2012, January 2013 and February 2013 that were signed/dated in April 2013 for Individual #300). In 10 (67%) cases, the completion dates of most PBSP monthly notes could not be identified because they were not signed or dated (i.e., Individual #26, Individual #61, Individual #297, Individual #325, Individual #275, Individual #55, Individual #46, Individual #118, Individual #7, and Individual #94). Overall, the counseling supports provided to individuals served by the Facility, as evidenced by the available documentation, appeared inadequate. This finding was consistent with findings from the Monitoring Team's previous reviews. Because this finding was consistent with observations reported in the Monitoring Team's previous reports, all of the concerns are not repeated here, and the Facility is strongly encouraged to review the findings and recommendations stated within the Monitoring Team's previous reports. In addition, the Monitoring Team acknowledged the expectation for comprehensive and rigorous counseling treatment plans, as similar to PBSPs, as recently presented by State Office Coordinator for Psychology/Behavioral Services. The Monitoring Team's previous reports had encouraged the Facility to examine evidence-based assessment practices that likely would facilitate the identification of functional skill areas as well as implement evidenced-based practices with regard to the specialized programming being developed for individuals with Autism or other developmental disabilities. Examples of these, including the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) and the Picture Exchange Communication System (PECS), were cited in previous reports. And, although evidence was provided that the ABLLS-R was purchased, no evidence was provided that it had yet been utilized. Similarly, as noted with regard to Section S.2 of the Settlement Agreement, there was no evidence provided that that skill programs related to the PECS system continued to be implemented. However, there was evidence that counseling groups (e.g., Cognitive-Behavioral Therapy) had been initiated using evidence-based interventions by one of the two contracted counselors. Future plans appeared to include the initiation of a similar group utilizing Dialectical Behavior Therapy, once appropriate resources were identified. Due to the continued inadequacy of counseling treatment plans and the monitoring of these plans, the Facility remained out of compliance with this provision of the Settlement Agreement.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual	Some progress was noted in the area of PBSPs as the continued use of the most recently revised format was observed.	Noncompliance

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	PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	The Monitoring Team's previous report noted findings from a small sample of individuals who had PBSPs completed using the newest PBSP format. At that time, it was reported that the new PBSP format appeared much more concise and user-friendly compared to previously reviewed documentation. That is, it appeared that a substantial amount of unnecessary and redundant information was removed. In addition, the format was structured to facilitate performance following competency-based training as well as ongoing integrity checks. Overall, the review evidenced an improvement in the quality of these plans. Current summary documentation (i.e., "CCSSLC PBSP," not dated, TX-CC-1301-VIII.19) indicated that there were approximately 125 individuals with PBSPs. Of these, it appeared that approximately 54 were updated within the last six months (i.e., 10/1/12 through 3/31/13). In an effort to review the adequacy of these PBSPs and assess progress toward compliance within this provision of the Settlement Agreement, a sample of six PBSPs was selected and reviewed. This sample reflected approximately 5% of the total number of PBSPs currently in place and 11% of those completed within the last six months. Of the six PBSPs reviewed, it was found that: ▪ Six (100%) included a rationale or purpose for development or revision; ▪ Four (67%) included adequate operational definitions of target behavior. The exceptions were Individual #295 and Individual #147; ▪ Two (33%) included adequate operational definitions of replacement behavior. The exceptions were Individual #147, Individual #77, Individual #42, and Individual #159; ▪ Five (83%) included baseline data (in graphic form) of target behavior. The exception was Individual #42; ▪ Two (33%) included baseline data (in graphic form) of replacement behavior. The exceptions were Individual #147, Individual #42, Individual #159, and Individual #167; ▪ Five (83%) included a description of previous intervention strategies and outcomes. The exception was Individual #147; ▪ Three (50%) included a behavioral objective for the target behavior. The exceptions were Individual #147, Individual #77, and Individual #167. It should be noted that the behavioral objective would be stronger for Individual #295 with an improved operational definition; ▪ Five (83%) included a behavioral objective for the replacement behavior. The exception was Individual #77. It should be noted that the behavioral objective would be stronger for Individual #147, Individual #42, and Individual #159 with an improved operational definition; ▪ Four (67%) appeared to include adequate descriptions of establishing operations/setting events, antecedents and consequences. The exception was Individual #295;	

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		▪ Four (67%) appeared to provide an adequate description of potential function(s) of target behavior. The exception was Individual #77 and Individual #295. However, concerns were noted with the use of technological language (as discussed below); ▪ Six (100%) included antecedent-based or preventative strategies. However concerns were noted regarding the comprehensiveness of the strategies offered for Individual #159, and the inclusion of consequence-based strategies in this section for Individual #295 and #147; ▪ Six (100%) included teaching strategies targeting the replacement behavior; ▪ Five (83%) included consequence-based or "intervention" strategies – the exception was Individual #147; ▪ Six (100%) included strategies to use positive reinforcement; ▪ Six (100%) included data collection strategies; ▪ Three (50%) included adequate strategies to reduce the intrusiveness of strategies and criteria for discontinuation of the PBSP. The exceptions were Individual #77, Individual #159, and Individual #167; ▪ Six (100%) included the signature and date. However concerns were noted regarding the timely completion for Individual #295, Individual #77, and Individual #42; ▪ Six (100%) included the formatting for conducting integrity checks, but only one (17%) included the instructions/scoring section (i.e., Individual #147); and, ▪ Six (100%) included a two to three-page "staff instructions" section. In an effort to provide more specific feedback, observations noted during the review of each individual's PBSP is offered below: ▪ Provided information (under behavioral and environmental issues, setting events, antecedents, precursors, and consequences) in the PBSP for Individual #295 did not appear to be consistent with the identified function (access to tangibles). Indeed, the information appeared to suggest that his outbursts might be due to an underlying escape function. Operational definitions for target and monitored behaviors in the PBSP contained terminology that was vague (e.g., "aggressive behavior" and "daily hygiene skills"), and, for the behavior to be monitored, included information unrelated to the actual definition. Information appeared to be included in inappropriate sections (data collection instructions under reinforcers and reinforcement schedule as well as consequence-based procedures included in the "prevention" section). Information also appeared to be redundant. This included the function of behavior that was found in multiple sections as well as in the hypothesis statement. The description within the "benefits" section did not appear to be related to the target or replacement behaviors or to the primary teaching strategies. In addition, the risks section did not appear to describe any related risks. Lastly, it was unclear why the author	

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		would sign and date the plan two weeks prior to the listed "date of revision." ▪ The operational definitions for the target and replacement behaviors described in the PBSP for Individual #147 were vague and incomplete. That is, it was unclear from the definition of "rummaging behavior" if the wardrobes belonged to him and/or others and whether or not looking through his own wardrobe would be included within this definition. In addition, identifying the function of the behavior in the definition appeared confusing and unnecessary. In addition, although the replacement behavior appeared related to the function of the target behavior, the Monitoring Team questioned whether or not it was an actual replacement behavior (e.g., wanting to change clothes or feel different textures as described, not just placing socks in a container). It was not clear from the current interventions described if there were previous interventions that were (or were not) successful. The hypothesis statement (i.e., "… the primary function of [Individual #147]'s rummaging through clothes in the bedroom is access to non-social" was a bit cryptic and potentially unclear to non-behavioral readers. There was no behavioral objective identified for the target behavior. The operational definitions of the target and replacement behaviors in the staff instructions section were different that those presented earlier in the PBSP. Although the behavior was described as primarily occurring at home, the majority of teaching strategies targeting the replacement behavior appeared to be prescribed within a classroom setting. Although this setting could certainly be used as a supplemental setting to teach these skills, it appeared somewhat inadequate to not more robustly provide similar levels of teaching at home. Although many of the prevention strategies appeared adequate, consequence-based interventions were included as well. The consequence procedures appeared to describe the consequences related to function of behavior and not offer prescribed instructions for staff in how to respond following an episode of rummaging behavior. ▪ The operational definition provided for the replacement behavior in the PBSP for Individual #77 was vague and potentially confusing (i.e., "appropriate access to physical/nonsocial"). That is, it was unclear what exact response was being defined and hopefully measured (i.e., was it staff offering her a choice or the act of her choosing?). Similarly, the hypothesis statement (i.e., "the function of [Individual #77]'s targeted behaviors appears to be physical/nonsocial") appeared cryptic and not easily understandable to non-behavioral staff. One potential consequence that appeared missing, especially given the comprehensive description of potential setting events (including sources of physical discomfort), was pain alleviation. Although a "fading" section was included, the revision or discontinuation criterion was not objective or measureable. Lastly, it was unclear why the plan was signed and dated five months after it was implemented.	

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		▪ One of the purposes identified in the PBSP of Individual #42 included "… to assist [Individual #42] with updating her programming." Although this statement reflected a pragmatic benefit to the IDT, it did not appear to target more clinically meaningful reasons for the PBSP. The operational definition provided for the replacement behavior was unclear and appeared to include staff instructions on how to prompt an appropriate response. The data provided within the PBSP only included data on "psychotic agitation" which was not defined. Lastly, it was unclear why the plan was signed and dated over four months after it was implemented. ▪ The operational definition of the replacement behavior identified in the PBSP of Individual #159 did not adequately describe how the individual makes choices. In addition, it appeared to be targeting two different responses. Plus, it was unclear how the identified replacement behavior was related to the function underlying the target behavior. More specifically, it was obvious that the replacement(s) could act as an incompatible response, however it was not obvious if it was a functional replacement. In addition, data presented in the PBSP (i.e., "attention to task with preferred items") did not appear directly related to the replacement behavior (i.e., choosing items to hold). Consequently, it was unclear why data on the actual replacement behavior was not included or if this was the correct data and the graph was mislabeled. The primary reason this was unclear to the Monitoring Team was the inadequate definition of the replacement behavior. The hypothesis statement was unclear and perhaps not helpful. In addition, the provided prevention and intervention strategies appeared inadequate given the nature of the target behavior. It would seem that more robust strategies (pica sweeps, supervision, etc.) would be clearly prescribed here in an attempt to make her environment as safe as possible. ▪ Data on the identified target behavior was provided in the PBSP for Individual #167, but data on the identified replacement behavior (i.e., asking for a break) was not provided. In addition, there was no date identified within the behavioral objective for the target behavior. Lastly, it appeared that the format of the staff instructions section was re-organized. Overall, given the concerns noted above, the PBSPs appeared to reflect an improvement over previously reviewed plans, especially with regard to the "staff instructions" section. However, many of the concerns noted above were consistent with those identified within the Monitoring Team's previous reports. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the PBSPs, a subsample of plans was selected and related approvals (i.e., BSC approval and guardian consent) were examined during the onsite visit. This sample of consents included five individuals, and represented approximately	

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		four percent of the total number of PBSPs currently implemented (N=125). Onsite documentation review revealed that only three (60%) of the individuals sampled had all of the necessary and current consents in their records. Exceptions included missing consents for Individual #237, and missing BSC approval for Individual #279 at the time of the onsite review. The Facility also provided documentation to reflect the number of PBSPs for which consent was obtained more than 30 days after plan development. According to provided documentation (TX-CC-1301-VIII.29), it appeared that approximately 28 (22%) individuals received consent more than 30 days after the PBSP was developed. Additional documentation (i.e., "List of Individuals with outdated PBSPs) provided by the Facility indicated that 26 (21%) individuals currently had outdated PBSPs due to the inability to obtain consent or delayed approval. Further examination of provided documentation (i.e., CCSSLC Positive Behavior Support Plans) indicated that approximately 41 (33%) individuals appeared to have their PBSPs implemented prior to receipt of consent. More specifically, approximately 41 individuals in the summary listing appeared to receive consent (as reflected by the recorded "consent date") after the PBSP was implemented (as reflected by the "implementation date"). In addition, review of the same documentation indicated that approximately 12 (10%) were implemented 14 days or more following receipt of consent. More specifically, approximately 12 individuals in the summary listing appeared to have their PBSPs implemented (as reflected by the "implementation date") more than 14 days following the receipt of consent (as reflected by the "consent date"). The Monitoring Team found these numbers surprisingly high, and, given the concerns about the accuracy of the database (i.e., as previously discussed with regard to Section K.7 of the Settlement Agreement), questioned the accuracy of the data. The Facility remained in noncompliance because the quality of behavioral programming was not sufficient for the newest plans and had not been generalized to the majority of PBSPs. In addition, concerns regarding adequate receipt of consent as well as the timeliness of implementation remained.	
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.	Progress continued to be noted in area of data display and ongoing PBSP monitoring, including conducting inter-observer agreement checks on collected behavioral data. As previously discussed with regard to Section K.4 of the Settlement Agreement, progress continued to be evident in the use of monthly monitoring PBSP progress notes. More specifically, the monthly PBSP progress note appeared to be well integrated as 10 (100%) of the individuals sampled had monthly notes completed (using the new format) for the requested time sample of December, January, and February. It appeared that the majority of monthly notes used graphs to effectively display target and replacement	Noncompliance

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	Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	behaviors as well as used both graphic and table formats to display medication and dosages. However, significant concerns were noted with the timeliness of the majority of monthly notes as well as the clinical descriptions and summaries provided with those notes reviewed. In an attempt to more closely examine the quality of current data collection, display and monitoring and, consequently, assess progress toward compliance within this provision of the Settlement Agreement, a sample of 10 individuals who had an ISP meeting within the last six months (between 10/1/12 and 03/31/13) and who also had a PBSP were selected and reviewed. This was the same sample as described above with regard to Section K.4 of the Settlement Agreement. This examination included the review of the PBSP monthly notes from December, January, and February for each individual sampled. Review of provided PBSP monthly notes indicated that, of the 10 individuals sampled: ▪ 10 (100%) included graphed data across months; ▪ 10 (100%) included one or more graphs displaying target behavior(s); ▪ 10 (100%) included one or more graphs displaying replacement behavior(s); ▪ Six (60%) included a graph displaying medication (and dosages). It should be noted that the absence of a medication graph did not necessarily reflect inadequate data collection (the individual might not be on medications); ▪ 10 (100%) had X axis labels (months); ▪ Nine (90%) had Y-axis labels. The exception was the medication graph for Individual #312 that identified "frequency" as the Y axis label for medication dosages; ▪ 10 (100%) utilized condition lines and condition paths; ▪ 10 (100%) appeared to have data paths; and ▪ Eight (80%) had data path labels. The exceptions included missing data path labels for medications and/or behavioral data for Individual #77 and Individual #42. Overall, significant improvement in the use of graphic displays was observed in the current sample. However, minor concerns were noted and are included here for the Facility's consideration. These included: 1) the continued use of color data paths that were difficult to view (discriminate) in black and white (e.g., Individual #312); 2) the use of a combined table and graph to display medications (e.g., Individual #141) appeared redundant; and 3) combined medication and behavioral graphs are only helpful if dosages change over time (e.g., Individual #77). Several tables were used to show medication dosages effectively and appeared easier to integrate into documentation than graphs. One example of where data was effectively displayed, including the target behavior data paths and condition change lines and text to illustrate potential effects of medication changes and other variables on behavioral responding was in the December monthly note for Individual #167.	

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		According to summary documentation provided by the Facility, IOA probes "occurred sporadically" since the Monitoring Team's last report. Review of provided data revealed that the majority of IOA probes occurred in January 2013. More specifically, it appeared that two (1%), two (1%), three (2%), zero, 10 (6%), nine (5%), 50 (30%), and 90 (54%) IOA probes were completed in June, July, August, September, October, November, December, and January, respectively. In total, reports indicated that 167 IOA sessions were completed by psychologists and/or psychology assistants and produced estimated agreement coefficients from 80 to 100%. As previously described with regard to Section K.4 of the Settlement Agreement, progress continued in staff collecting inter-observer agreement (IOA) data. As reported in the Monitoring Team's previous report, it was expected that IOA data be reported in all monthly PBSP progress notes. As found at that time of the last review, sampled monthly PBSP notes evidenced the collection of IOA data for six (60%) of the individuals sampled. This was an improvement as no evidence of IOA data collection was previously provided. Currently, IOA probes were reported in one or more of the monthly notes for nine (90%) of the individuals sampled. However, concerns were noted with how this data was reported. That is, although probes were discussed within the monthly notes for nine (90%) individuals, data reported regarding the IOA probes appeared complete (adequate) for only six (60%) of the individuals sampled. More specifically, several notes did not provide actual IOA data including information on when the IOA probes were conducted, the specific response targeted, the number of probes conducted, and/or the actual IOA estimate generated (i.e., PBSP monthly notes for Individual #77, Individual #159, Individual #167, and Individual #177). Overall, it appeared that IOA data was increasingly being collected. However, additional data and specification was required. The Facility should consider collecting IOA data on multiple target and replacement behaviors and reporting IOA estimates separately for each behavior examined. In addition, direct support professionals should ultimately be integrated into these observation sessions as well. Indeed, these are the staff where the demonstration of acceptable agreement estimates is most important. According to summary documentation, treatment integrity checks began on 12/10/12 for individuals with PBSPs. The stated expectation included the completion of one integrity check each month for each current PBSP. As previously described, the "staff instructions" section on the PBSP was formatted to accommodate scoring of these integrity checks. These checks were completed within the "naturally occurring environment" and targeted direct support professionals who received competency-based training. Checks typically involved psychologists or psychology assistants asking direct support staff questions about an individual's PBSP as well as asking them to demonstrate required skills. Collected data indicated whether or not staff were able to answer the	

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		question or perform the skill accurately and whether or not re-training was provided. According to provided data, 98 integrity checks were completed since 12/10/12. Provided data indicated that approximately two or more integrity checks were completed at most residential programs, with the exception of Residence 515 where no checks were completed. Data indicated that between two and 29 integrity checks were completed across residential programs, including less than eight checks completed in seven (70%) of the residential programs. Reported scores ranged 81 to 100%. Overall, data reflected that this comprehensive process of estimating the quality of integrity of staff implementation of PBSPs had just begun. Although progress was noted in the areas of progress monitoring, the Facility remained out of compliance with this provision because of the continued inadequacy of IOA and treatment integrity data collection.	
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.	The Facility continued efforts in writing PBSPs so that they could be understood and implemented by direct support professionals. However, data was not provided that evidenced adequate readability estimates or staff instruction sections of the PBSPs. As described in the Monitoring Team's previous reports, the Facility utilized a revised PBSP "staff instructions" format as well as monitored the readability level of the included text to ensure that PBSPs can be understood and implemented by direct care staff. As previously described with regard to Section K.9 of the Settlement Agreement, all staff sampled had "staff instructions" sections completed. In addition, according to verbal reports, the readability level of the PSBP continued to be examined and reviewed during BSC meetings. The readability standard (criterion) was recently changed from a readability of 7th grade (or lower) to a readability estimate of 8th grade (or lower). According to the Director of Behavioral Health Services, if a plan were to exceed that criterion, the plan would need to be revised and, would only be approved by BSC if the plan met that readability criterion. Although verbal reports indicated that recently approved PBSPs would be at or below the expected readability criterion, the Monitoring Team could not confirm this for the current sample. More specifically, readability estimates on the currently sampled PBSPs were not provided. Confirmation of these estimates appeared necessary as provided data indicated that many approved PBSPs exceeded the set criterion. That is, data as reported within the Facility's Self-Assessment identified 15% of their sample was at or above an 8th grade reading level. As previously presented with regard to Section K.9, a sample of six PBSPs was selected and reviewed in an effort to review their adequacy. This sample reflected approximately 5% of the total number of PBSPs currently in place and 11% of those completed within	Noncompliance

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		the last six months. This sample was utilized to determine if the PBSPs were written so that they could be understood and implemented by direct care staff. More specifically, the "staff instructions" section of these PBSPs was closely reviewed to assess progress toward compliance within this provision of the Settlement Agreement. Of the six staff instructions sections of the PBSPs reviewed, it was found that: ▪ Four (67%) included adequate operational definitions of target behavior. The exceptions were Individual #295 and Individual #147; ▪ Two (33%) included adequate operational definitions of replacement behavior. The exceptions were Individual #147, Individual #77, Individual #42, and Individual #159; ▪ Six (100%) included antecedent-based or preventative strategies. However concerns were noted regarding the comprehensiveness of the strategies offered for Individual #159, and the inclusion of consequence-based strategies in this section for Individual #295 and #147; ▪ Six (100%) included teaching strategies targeting the replacement behavior; and ▪ Five (83%) included consequence-based or "intervention" strategies – the exception was Individual #147. In general, it appeared that only one (17%) of the staff instructions sections of the sampled PBSPs was adequate and likely to promote effective understanding and implementation direct care staff. Although some progress was noted above, the Facility remained in noncompliance with this provision due to the continued rollout of the new PBSP format, lack of evidence that appropriate readability estimates of sampled PBSPs, and the Monitoring Team's review of a sample of ISPs that indicated that the could not be easily understood by staff.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Some progress was made with regard to competency-based training. According to data provided within the Facility Self-Assessment, between 5/1/12 and 1/31/13, 941 competency-based training sessions had been completed for 69 individuals with PBSPs. The Facility also estimated that 57% of those with PBSPs had staff that were trained to competency. It should be noted that the Monitoring Team was not able to confirm these numbers. These numbers suggested that many, if not most, of the trainings were conducted with only one or a few staff at one time. This is consistent with verbal reports during the Monitoring Team's previous visits about how competency-based training was being implemented. That is, as presented in the Monitoring Team's last report, staff described a direct service delivery model where the psychologist or psychology assistant trained a single direct care staff member. As previously presented, it appeared that this model was inappropriate and should not be the typical training model utilized. An indirect model should be employed where the	Noncompliance

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		psychologist (i.e., "expert") provides competency-based training to other trainers (e.g., psychology assistants, home team leaders, etc.) who share the responsibility in training the direct support professionals. The psychologist or one of these other competent trainers should train direct support professionals in small groups. That is, only individuals who have successfully demonstrated competence in what they are teaching (e.g., a particular PBSP) and also have demonstrated competence as a trainer (i.e., teacher) should conduct the training. Provided documentation did evidence a substantial amount of training on PBSPs completed since October 2012. However, evidence was not provided that a substantial number of employed staff member (implementing PBSPs) was trained to competency using competency-based training. In addition, as presented with regard to Section K.10, although implementation of integrity checks had begun, this process was still inadequate. The Facility should identify the individuals who demonstrate the most at risk behavior and, consequently, determine which PBSPs require the most immediate treatment integrity checks. These checks should be completed for all staff members who are responsible for implementing these PBSPs. In addition, the Facility should identify a process for demonstrating competency for challenging behaviors that occur very infrequently. During the most recent onsite review, direct observation of a training by a member of the Monitoring Team noted efforts to ensure that trainers were competent in providing competency-based training. More specifically, experienced psychologists observed and provided feedback to a less experienced trainer who conducted training on a PBSP for a single direct support professional. The training included many elements of active teaching but could have been more active on the part of the trainer and trainee, including many more opportunities to practice consequence-based interventions. However, these efforts will likely improve the competency of trainers by providing critical feedback regarding their use of role-playing, modeling, demonstration/coaching, and performance feedback. Although some progress had been made, the provision of adequate competency-based training across the Facility remained inadequate for the reasons noted above. As a result, the Facility remained in noncompliance with this provision.	
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	At the time of the most recent review, based on verbal report and documentation provided, there were 14 Associate Psychologist (i.e., four Associate Psychologist V and ten Associate Psychologist III) positions, a Clinical Psychologist, and a Director of Behavioral Health Services. One Associate Psychologist position was open. Currently, the Director, Clinical Psychologist, and one Associate Psychologist V were BCBAs. In	Noncompliance

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	professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	general, only the Associate Psychologists carried a formal caseload. However, it was reported that both of the new BCBAs (i.e., Clinical Psychologist and Associate Psychologist V) have completed some PBSP writing. Currently, there were seven Psychology Assistants and one open (0.5) Psychology Assistant position. As of the most recent onsite review, CCSSLC served 246 individuals. Due to the one open Associate Psychologist position, there were 13 Associate Psychologists. Based on these numbers and the understanding that the Clinical Psychologist and Director of Behavioral Services did not formally carry a caseload, an approximate average psychologist-to-individual ratio was estimated at 1:19. Given reports provided, there was one Psychology Assistants for every two Associate Psychologists employed. The Facility was rated as being in noncompliance with this provision, because, as noted with regard to Section K.1, the professionals in the Behavioral Health Services Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement. This was evidenced by the absence of professional certification, as well as by issues related to the quality of the programming observed at the Facility.	

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

1. CCSSLC should develop, implement, and monitor a plan for each staff member who remains reluctant to take graduate coursework toward the BCBA. This should include working collaboratively to identify remaining obstacles and problem-solve regarding his or her unwillingness or inability to pursue professional competencies in ABA. This should include contingencies for staff unwilling to pursue board certification. (Section K.1)
2. CCSSLC should ensure that contracted BCBA professionals have sufficient time to adequately supervise staff members enrolled in coursework, and that they do so according to supervision guidelines outlined by the Behavior Analysis Certification Board. (Section K.1)
3. Behavioral services staff should ensure that they are documenting on required BACB forms, and tracking their supervision over time, in accordance with supervision guidelines outlined by the Behavior Analysis Certification Board. (Section K.1)
4. The Facility should attempt to identify and overcome barriers to attendance by BSC members to help ensure adequate peer review. Peer review policy should be revised to accurately reflect changes in the expected diversity of BSC. (Section K.3)
5. The Facility should continue to ensure ongoing external peer review, including the consistent review of CCSSLC behavioral programming to some degree during each opportunity. (Section K.3)
6. Polices regarding internal and external peer review should be updated to reflect current practice. This should include specific items related to the agendas of BSC and external peer review, as well as identification of the professionals who need to be in attendance to ensure adequate critical peer review. (Section K.3)
7. With regard to monthly PBSP notes, the Facility should:
    a. Ensure timely completion of PBSP monthly notes.
    b. Ensure that staff's comments are descriptive, clinically meaningful and individualized, as appropriate, for each month reviewed.
    c. Ensure that complete data (e.g., date, response(s) targeted during IOA, IOA estimate) is provided when describing IOA probes. (Section

K.4)

9. The Facility should examine ways to make the evaluation more concise, perhaps by eliminating much of the raw data, as well as reducing the redundancy of the content. (Section K.5).
10. The Facility should consider tracking the number of assessments or plans that require revision prior to BSC approval. This could include tracking whether or not these were completed in time to inform the ISP process as well as the time it took to receive necessary consents and approval. This might be an indicator of the quality of peer review and could inform the interpretation of the delinquency report. (Section K.7)
11. Rigorous counseling treatment plans should be developed, expanded, and/or refined to include measureable outcomes, and treatments should be evidenced-based. Recent changes within CCSSLC practices in this area should be included in revisions to current policy and/or procedures. (Section K.8)
12. The empirical support should be reviewed for any assessment methodologies or therapy strategies provided to individuals served by CCSSLC, whether on or off campus. In addition, the utilization of evidenced-based assessments (e.g., The Assessment of Basic Language and Learning Skills) and/or practices (e.g., functional communication training, picture exchange communication system, etc.) should continue to be pursued, utilized, and evaluated to determine its effectiveness compared to alternative therapies. (Section K.8)
13. The use of evidenced-based interventions within PBSPs should be more conspicuous. The conspicuous use of accepted practice, such as differential reinforcement strategies (e.g., DRO, DRA, etc.) should be used as appropriate. (Section K.9)
14. The Facility should ensure that Staff should ensure that a brief section on history of previous interventions, as well as reducing restrictiveness (of behavioral interventions and strategies, not just medication) is included in PBSPs. It is important to provide a background on ineffective procedures, as well as specific criteria (clear objectives) of behavioral progress (or deterioration), and to include measurable objectives for target and replacement behaviors, which would identify when team reviews or PBSP revisions would be considered. Levels of supervision or other restrictive procedures (e.g., use of mitts) should be identified within a hierarchy, and goals should be established for the fading of restrictive practices based on performance. (Section K.9)
15. The Facility should ensure that critical elements of PBSPs are adequately included or cited within all newly developed and/or revised PBSPs. Emphasis should be placed on operationally defining replacement behaviors, identifying preventative teaching strategies that target the acquisition and use of replacement behaviors, and regularly assessing reinforcers (through preference assessments), and ensuring they are individualized, robust, and clearly prescribed in both antecedent and consequence based approaches. (Section K.9)
16. The Facility should continue to expand and move forward with the assessment and monitoring of inter-observer agreement for PBSP target and replacement behaviors. Staff are encouraged to review the textbook Applied Behavior Analysis (2nd edition) by Cooper, Heron, and Heward (2007) for more specific information on conducting IOA and inter-rater agreement. (Sections K.4 and K.10)
17. 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. (Section K.10)
18. Treatment integrity data should be expanded as well as summarized and examined. The collection and review of this data is necessary to ensure confidence that programs are implemented as written, and that the system is being responsive to issues related to poor integrity. (Section K.10)
19. The Facility should add readability estimates to all PBSPs. (Section K.11)
20. The Facility should develop a listing of all current direct support professionals that implement PBSPs and identify the dates they received competency-based training for the individuals that they support. (Section K.12)
21. The Facility should identify those individuals who are at highest risk and, consequently, prioritize which PBSPs necessitate competency-based and integrity checks for all staff who support those individuals. (Section K.12)
22. The Facility should identify a process for demonstrating competency for challenging behaviors that occur very infrequently. (Section K.12)
23. The Facility should ensure that staff that are providing training are competent in providing competency-based training. This would include monitoring psychologists or other trainers as they provide trainings. In addition, data collection on the integrity of psychologists' completion of didactic and demonstrative competency-checks would be beneficial. (Section K.12).

24. The Facility should closely examine the model(s) being utilized to train direct care staff (i.e., beyond New Employee Orientation), and determine if it is appropriate. The Facility should consider using a more indirect service delivery model where the psychologists train a few key "trainers" who will share the responsibility of completing competency-based training with all direct support professionals. (Section K.12)

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

1. When appropriate, the amount of redundancy should be reduced within reports by integrating and summarizing information or avoiding the inclusion of information repeatedly throughout reports, such as data, definitions, objectives, strategies, etc. Similarly, when appropriate, the amount of redundancy should be reduced across reports. That is, some data and information is not needed across different reports. For example, specific information related to intelligence tests are not necessary in SFBAs or PBSPs. (All of Section K)
2. In providing documentation to the Monitoring Team, it should be dated and, when appropriate, signed by authors. This should include providing the original signed and dated documentation, not documents that were signed and dated at the time of the review. This is important for the Monitoring Team's review, but also to ensure that the Facility has mechanisms for ensuring that documents are the most current and final/approved versions, and that historical information can easily be tracked. (Section K)
3. The concerns regarding the potential of a "corrupted" Behavioral Sciences database continued to be significant problem, and inhibited the Monitoring Team's ability to determine the current status of psychological services, including providing an accurate review and valid estimates of compliance on the provisions of the Settlement Agreement. More importantly, the Facility needs an accurate and up-to-date mechanism to monitor the psychological services. (Section K).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o List of all staff who work in the Medical Department, including names and titles; o Name and CV of current Medical Director; o Name and degrees of all primary care providers new to the Facility since the Monitoring Team's last review; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing CPR training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Copy of Continuing Medical Education (CME) for each primary care provider, list of CME credits according to topics reviewed, and list per PCP of total CME credits since the Monitoring Team's last onsite review; o Copy of any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of Infection Control Committee meetings during the prior six months; o Minutes of Skin Integrity Committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken, including date of audit from which information retrieved; o For medical staff meetings (i.e., morning medical meetings, etc.), copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for the week prior to the monitoring team visit (e.g., from 3/25 through 3/29/13); o Most recent results/report of the Facility-wide medical review system, including copies of any non-facility physician review reports or data since the Monitoring Team's last visit, and separate reports/data of external medical peer review audits from internal medical peer review audits, including information concerning the number of corrective action plans, and the QA Department follow up of these corrective action plans; o List of individuals who died since the Monitoring Team's last visit. For each individual, submitted information included date of death, death certificate, whether an autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to the death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory; other submitted information included location at time of death, whether DNR (i.e., in hospital, out of hospital, etc.) whether on hospice or not, whether ambulatory, whether the individual was prescribed supplemental oxygen as part of routine care, and date

	of any ethics committee meeting that reviewed the individual's terminal course, if applicable, for the following individuals: Individual #76, Individual #168, Individual #176, Individual #64, Individual #117, Individual #357, Individual #378, and Individual #195; o Mortality Reviews (e.g., clinical, administrative, and nursing reports) since the Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations); o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (clinical/administrative) that remained incomplete/outstanding; o Twenty recent annual medical assessments, physical examinations and prior annual assessments and examinations for the following individuals: Individual #260, Individual #295, Individual #341, Individual #154, Individual #71, Individual #106, Individual #43, Individual #124, Individual #294, Individual #5, Individual #272, Individual #102, Individual #276, Individual #299, Individual #274, Individual #112, Individual #139, Individual #247, Individual #191, and Individual #312; o Monthly specialty clinic schedule for the past six months, which included the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the list of appointments missed for reasons other than refusals, the list of missed appointments (refusals) for which follow up appointments were made, the list of missed appointments (non-refusals) for which follow up appointments were made, the list of refused appointments for which a follow up visit was completed, the list of missed appointments (other than refusals) for which a follow up visit was completed, and the list of missed appointments for all reasons still outstanding; o List of all outside consultations for medical purposes for the past six months, categorized by specialty (i.e., the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, the appointments, the list of appointments missed for other reasons than refusals, the list of missed appointments (refusals) for which follow up appointments were made, the list of missed appointments (non-refusals) for which follow up appointments were made, the list of refused appointments for which a follow up visit was completed, the list of missed appointments (other than refusals) for which a follow up visit was completed, and the list of missed appointments for all reasons still outstanding); o For one individual from each residence, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit, and all integrated progress notes commenting on consultant reports (medicine and surgery inclusive of subspecialties), (agreeing or reason not agreeing) and any ISP

	addendum related to the consultant report; o A list of individuals with the following: ▪ Tracheostomies; ▪ Fractures, date of fracture, type of fracture (e.g., compound, simple, stress, etc.), and bone fractured (location); ▪ Injuries requiring visit to ER or hospitalization since the last on-site review; ▪ Pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last on-site review; o Policies or procedures for medical screening and routine evaluations; o For those over age 50, date of last colonoscopy, identification of reason for colonoscopy (i.e., preventive versus evaluation of active problem), with reason if not up-to-date; o For those women over age 40, date of last mammogram and reason listed if not up-to-date (i.e., guardian refusal, etc.); o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of individuals with diagnosis of osteopenia/osteoporosis with medications and dosage per person (e.g., calcium, Vitamin D, IV bisphosphonate, etc.), date of last DEXA scan or statement if not completed, copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (e.g., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (i.e., based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test; o For individuals going to the ER and not hospitalized, copy of integrated progress notes from start of signs/symptoms to transfer to ER, the ER report, discharge orders from ER and copy of Facility orders, integrated progress notes/Infirmary progress notes, follow up to any recommendations, for the 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations). Copies of this information were submitted for the following individuals: Individual #18 10/23/12, Individual #326 1/22/13, Individual #224 1/2/13, Individual #153 11/13/12, Individual #128 10/25/12, Individual #250 12/7/12, Individual #333 10/21/12, Individual #333 1/29/13,

	Individual #234 10/1/12, and Individual #95 12/24/12; o For those admitted to hospital, copy of integrated progress notes from start of signs/symptoms to transfer to ER, the ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, and follow up for any hospital discharge orders and recommendations, 10 most recent hospitalizations that have returned for at least 30 days (in order to allow completion of recommendations). Copies of the above information were submitted for the following individuals: Individual #182 1/25/13, Individual #275 1/8/13, Individual #144 1/28/13, Individual #89 1/12/13, Individual #304 1/30/13, Individual #326 1/7/13, Individual #155 1/14/13, Individual #127 1/22/13, Individual #234 12/27/12, and Individual #156 12/31/12; o For the above 10 hospitalizations, copy of hospital liaison nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months; o Infectious disease data per quarter by category of infection for the last two quarters; o Summary report or trend analysis of infectious disease/communicable disease for the last two quarters; o Avatar pneumonia tracking forms for the past six months; o For those with diagnosis of pneumonia during the last six months and taking food/liquid by mouth, type of liquid (amount of thickening), type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: ▪ Pneumonia; ▪ Decubitus Ulcers; ▪ UTIs; and ▪ Bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for the past year for individuals who have been newly diagnosed with the following: ▪ Malignancy; ▪ Cardiovascular Disease; ▪ Diabetes Mellitus; ▪ Sepsis; ▪ Bowel Obstruction or Bowel Perforation; and ▪ Pneumonia; o List of individuals who have a diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including the name of

	individual, residence, diagnosis (e.g., type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #325, Individual #340, Individual #294, Individual #70, and Individual #287; o List of individuals seen by Neurologist with dates on which appointments were completed and reason, and date of prior visit to the Neurologist, since the Monitoring Team's last visit; o List of those with status epilepticus since the last monitoring visit; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged/new onset seizure since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who were currently being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals on one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (e.g., Phenobarbital, Dilantin, Mysoline, Felbamate); o Any tracking of data for individuals who have transitioned to the community since the Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post Move Monitor and Community Service Coordinator at 90-day transfer; o For the three individuals most recently transitioned to the community for at least 90 days, seven, 45, and 90-day post-move monitoring reports. For these three individuals, copy of Community Living Discharge Plan (CLDP), most recent ISP, BSP, and subsequent addendums, most recent annual medical exam and most recent nursing assessment for: Individual #140, Individual #69, and Individual #231; o Since the Monitoring Team's last visit, any Ethics Committee meeting minutes, with attendance rosters, concerning DNR decisions/changes, or other concerns addressed by this committee; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (either on campus and off-site), list of appointments that were completed and ones not completed (with reasons); o Numbers of individuals with a diagnosis of seizure disorder on no anti-epileptic medications;

	o Number of individuals with VNS in place, with the date of placement, and date of replacement, if applicable; o For concerns identified needing closure at morning medical meetings for the period of 30-60 days prior to the Monitoring Team's visit, documents providing evidence of closure (e.g., minutes of medical staff meeting, copy of ISPA addressing concern, etc.); o For the last five individuals to whom pre-treatment sedation was administered for a medical procedure, all information related to medical pre-treatment sedation used prior to visits, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries. Information was submitted for the following individuals: Individual #260, Individual #190, Individual #210, Individual #56, and Individual #93; o Ten most recent PNMT recommendations with physician orders; o ISPAs addressing missed appointments or refusals for the past three months (for mammograms and colonoscopies); o List of missed medical appointments with reasons past six months; o Presentation Book for Section L; o DADS Preventive Health Care Guidelines, SSLCs, dated August 30, 2011; o For women age 21 to 65, list of individuals with date of last pelvic exam (i.e., including whether completed, attempted but unsuccessful, etc.), date of last Pap smear, whether the Pap was considered an adequate specimen, documentation of reason if pelvic was not completed, and documentation of reason if Pap smear was not done. For those with a history of hysterectomy, the reason for the hysterectomy; o For each of the following individuals, copies from the active record: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports past one year, DNR forms if applicable, physician orders past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews: Individual #297, Individual #278, Individual #244, Individual #340, Individual #273, Individual #159, Individual #65, Individual #70, Individual #266, Individual #158, Individual #46, Individual #319, Individual #128, Individual #181, Individual #111, Individual #350, Individual #269, Individual #193, and Individual #332; o For each PCP, a copy of the two most recently completed quarterly medical reviews from each assigned residence: Individual #122 2/13/13, Individual #278 1/9/13, Individual #83 2/1/13, Individual #22 2/13/13, Individual #294 2/1/13, Individual #24 1/17/13, Individual #56 1/28/13, Individual #32 1/9/13, Individual #77 1/17/13, and Individual #156 1/28/13;

	○ Minutes of the medical morning meeting during the Monitoring Team visit 4/1/13 to 4/4/13; ○ Medication history for individuals with J or G/J tubes (i.e., not G tubes); ○ For the self-assessment process, the monitoring tools used, with a description of the tools (i.e., the total number of the eligible population sampled, the number of the sample, the methodology used to select the sample, frequency of data collection, the staff that completed the audit/monitor survey/review, and any inter-rater reliability data obtained or analyzed for the audit/monitoring review; and ○ For the self-assessment process, the databases utilized (other than audit information), with a description of the database (i.e., title of each database/chart/table with date range of each database, and frequency of data collection for data collected periodically rather than continuously). ▪ **Interviews with:** ○ Ingela Daniellsson-Sanden, MD/PhD-MBA, Medical Director. ▪ **Observations of:** ○ Individual #122, Individual #232, Individual #15, Individual #334, Individual #101, Individual #79, Individual #126, Individual #161, Individual #260, Individual #278, Individual #303, Individual #244, Individual #154, Individual #342, Individual #21, Individual #205, Individual #366, Individual #43, Individual #22, Individual #104, Individual #212, Individual #57, Individual #124, Individual #189, Individual #183, Individual #160, Individual #280, Individual #70, Individual #229, Individual #150, Individual #24, Individual #93, Individual #270, Individual #305, Individual #272, Individual #307, Individual #16, Individual #266, Individual #252, Individual #276, Individual #23, Individual #134, Individual #239, Individual #319, Individual #222, Individual #250, Individual #299, Individual #274, Individual #25, Individual #50, Individual #113, Individual #130, Individual #146, Individual #163, Individual #292, Individual #328, Individual #181, Individual #324, Individual #350, Individual #301, Individual #236, Individual #293, Individual #127, Individual #240, Individual #68, Individual #201, Individual #290, Individual #37, Individual #32, Individual #245, Individual #195, Individual #77, Individual #247, and Individual #314; and ○ Integrated Clinical Services Meetings 4/2/13 to 4/4/13.
	Facility Self-Assessment: For Section L, in conducting its self-assessment, the Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included: external and internal medical peer review general medical and medical management audits, and quality indicator audits for constipation, seizures, ER/hospital visits, diabetes mellitus, osteoporosis, and

	hypertension. ▪ These monitoring/audit tools did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. There were many tools and reviews completed. However, the breadth of medical care remained a challenge when attempting to measure quality of care. Examples needing further review included quality of medical care in health status change and measuring the outcome/activities of the Integrated Clinical Services Committee. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ The monitoring tools did not include adequate methodologies, such as active record reviews. ▪ The Self-Assessment did identify the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes generally were adequate to consider them representative samples. ▪ External and departmental PCPs were responsible for completing the audit tools. The staff responsible for conducting the audits/monitoring had not been determined to be competent in the use of the tools. ▪ Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ The QA Department provided no data for inter-rater reliability. The Facility used some other relevant data sources and/or key indicators/outcome measures to show whether or not the intended outcomes of the Settlement Agreement were being reached. These included information from many databases with information on: annual medical assessments, quarterly medical assessments, osteopenia/osteoporosis, colonoscopies, mammograms, and off-campus appointments. ▪ The quality of the data maintained in the databases was noted to be complete and accurate. ▪ The Self-Assessment included information from databases that was not submitted either during discussion or in the Presentation Book and could not be verified. ▪ Some data was available in charts and graphs, but the supportive evidence was not submitted. More problematic was the analysis aspect of the Self-Assessment. There did not appear to be an aggressive approach to acting on trends for self-improvement. Some data was submitted only as raw data. As a result, the Facility did not consistently present data in a meaningful/useful way. In addition, in some instances, even when the Facility data identified some areas of need/improvement, the Facility Self-Assessment did not provide an analysis of the information. It did not identify, for example, the need for follow-up or the development of corrective action plans to improve quality of care, and/or reference the reader to such plans, if they already existed. The Facility rated itself as being in compliance with Section L.2. This was not consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: The Medical Department had a new Medical Director and a new

	Medical Compliance Nurse. There were also two new PCPs with short-term contracts. The data indicated that many of the areas of preventive care (e.g., colonoscopies, mammograms, etc.) had achieved levels of substantial compliance. This will need to be monitored, as the challenge will be to sustain these accomplishments. There were considerable remaining areas of challenge. The Medical Director was working on a part-time basis, but the administrative duties were a full-time job. The Integrated Clinical Services Committee had important structural components in place, but more critical thinking was needed, as well as assignment of follow-ups, with accountability of closure within a short period of time. Lists of unresolved concerns awaiting an ISPA to address issues should not occur, and the turnaround response by IDTs should be rapid. The Facility might need to provide support in mentoring and guiding IDTs in developing ISPAs, which provide a quality response to the Integrated Clinical Services Committee concerns. Currently, post hospital ISPAs did not focus on preventive care, but only on the immediate stabilization of the individual. Death reviews were problematic. There was often not a critical review of information leading to recommendations aimed at making systemic improvement. Another major concern was the lack of follow-up to recommendations from the administrative death reviews. Some of the recommendations had system implications, but were not implemented and monitored until completion. Overall, considerable data was available. However, there was little evidence of analysis that led to changes in systems to improve medical services. Policies and procedures need to be written to reflect the various aspects of medical services, and the interface with other departments at CCSSLC.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections 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, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> The information submitted for the current Monitoring Team's visit showed the Facility had a Medical Director and four PCPs responsible the medical care. There were two State employed primary care physicians, and two contract primary care physicians. The Medical Director was a part-time State employee who started work at CCSSLC on 1/16/13. For one contract PCP, the contract start date was 11/26/12, and the end date	Noncompliance

#	Provision	Assessment of Status	Compliance
	professional standards of care with regard to this provision in a separate monitoring plan.	was 8/31/13. For the other contract PCP, the start date was 3/4/13, and the end date was 4/24/13. As of 4/4/13, with a Facility census of 246, PCP caseloads were as follows: two state employed PCPs with 49 to 58 individuals, and two contract PCPs with 58 to 81 individuals. The Medical Director had no caseload. Since the Monitoring Team's last visit, the Medical Department also listed two additional contract PCPs who were no longer at the Facility. A contract nurse practitioner worked from 10/16/12 through 12/18/12. A contract MD worked from 9/17/12 through 11/16/12. Since the Monitoring Team's last visit, the Compliance Nurse position had become vacant but a new Compliance Nurse started working on 3/1/13. The Medical Department also had one Medical Administrative Assistant and a Medical Program Specialist. Additionally, under the Medical Department administration, there was one Respiratory Care Practitioner (RCP), and one Respiratory Technician (Med Tech). A list, dated 4/3/13, was submitted indicating those members of the Medical Department that remained current in cardiopulmonary resuscitation (CPR) certification. Of the primary care providers in the department, four out of four (100%) were current in CPR. The Medical Director was also current in CPR certification. The Respiratory Care Practitioner and Respiratory Tech were also current in CPR certification. For the five current PCPs in the Medical Department, a list of CME credits since the Monitoring Team's previous visit was submitted for two of five of these PCPs. The purpose of reviewing CME was to determine if the CME focused on diagnoses and topics that would enhance the practice patterns of the PCPs at the Facility. One PCP completed three hours and one PCP completed 19.25 hours. The 19.25 hours focused on primary care, but no further details were provided. The three hours of CME involved administrative issues. There was no information submitted that demonstrated CME was obtained by the five PCPs concerning educational programs that focused on the IDD population. However, primary care updates are essential to quality care of the IDD population. In summary, since the last Monitoring Team visit, one of five (20%) of PCPs demonstrated CME important to care of the individuals at CCSSLC. <u>Physician Participation In Team Process</u> For the three morning medical meetings observed, there was a separate computerized attendance roster in zero of three (0%) meetings. It is recommended that the Medical Department work with the Information Technology Department in developing a computerized system that can be used to track attendance per month and quarter per	

#	Provision	Assessment of Status	Compliance
		department. There was a signed attendance roster in three of three (100%) meetings. Departments represented at the morning medical meeting on a daily basis included the following: ▪ Medical Department staff (i.e., Medical Director, PCPs, Medical Compliance Nurse, Medical Program Specialist); ▪ Nursing Department staff (i.e., RN Case Manager Supervisor, Infirmary nursing, Infection Control Nurse, Hospital Liaison Nurse); ▪ Psychology Department; and ▪ Pharmacy Department. Departments represented at the morning medical meeting on a weekly or periodic basis included Psychiatry Department, Dental Department, PNMT, and the QDDP Coordinator. For the three morning medical meetings observed, there were zero new hospitalizations, one ER visit (Individual #301), and four admissions to the Infirmary (Individual #153, Individual #127, Individual #194, and Individual #67). During these three days of team meetings, there had been four ongoing hospitalizations. Based on the Monitoring Team's observations and review of documentation: ▪ **Critical review with IDT follow-up with ISPA:** For zero of four (0%) hospitalized individuals were critical clinical questions raised followed by a request for the IDT to meet to review the case to identify preventive measures (e.g., early clinical signs/indicators, environmental issues, medication interactions, positioning, monitoring of positioning, etc.), with subsequent development of an ISPA, if indicated. ▪ **Critical review with IDT follow-up with ISPA:** For zero of two (0%) applicable Infirmary admissions were critical clinical questions raised followed by a request for the IDT to meet to review the case to develop preventive measures, with subsequent development of an ISPA, if indicated. ▪ **Critical review with IDT follow-up with ISPA:** For zero of one (0%) ER visits were critical clinical questions raised followed by a request for the IDT to meet to review the case to develop preventive measures, with subsequent development of an ISPA, if indicated. It was noted that members of the committee engaged in critical clinical discussion concerning the individual with an ER visit on 4/2/13, but there was no referral for further IDT involvement. ▪ **Assignment of follow-up to meeting participant:** There were at least two cases about which the Medical Director raised/identified critical clinical questions, identifying the need for closure. These were followed by assignment of the concern for further review by one or more morning medical meeting attendees to identify additional steps in treatment and prevention. However,	

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		these assignments did not appear to be documented in the minutes. ▪ **Formal record review:** For zero of four (0%) hospitalized individuals (Individual #139, Individual #128, Individual #179, and Individual #327) was there a request for a formal record review to determine preceding events, monitoring intensity, etc., before the onset of acute illness. ▪ **Assignment of open book/record review:** As a subset of those hospitalized, for those with aspiration pneumonia, reactive airway disease, recurrent pneumonia with undetermined etiology, respiratory failure, or sepsis with undetermined etiology, there were zero assignments for two hospitalizations (0%) requesting an open book review for the prior seven to 14 days of the illness to review monitoring of care, positioning documentation, feeding concerns, early warning signs that could have been assessed and reported to the PCP, discussion of involvement of the PNMT, listing preventive areas to be considered based on the diagnosis causing the acute illness, adequacy of medical evaluation, need for consultation, and/or review of medication and medication side effects, etc. ▪ **Closure discussions:** There was one prior concern with assignments for follow-up that was presented at the medical morning meetings. At the start of the Monitoring Team's visit, at the morning meeting, there were eight individuals previously hospitalized or in the Infirmary needing an ISPA. Of these, one was reported closed by the last day of the Monitoring Team's observation of the morning meeting. The list of individuals needing closure with an ISPA on the last day of the Monitoring Team's onsite review was nine. Of significant concern, one individual had NPO status, but on 3/25/13, was observed to be coughing up Fritos. The group requested an ISPA response by the IDT by 4/1/13, which did not occur. ▪ **Requested ISPAs reviewed:** There was one brief summary of an ISPA for an individual returning from the hospital for pneumonia. This was accepted, but reference/content of the discussion was not recorded in the minutes. It is recommended that the minutes include a brief summary of the ISPA's response to the concern to ensure the content of the ISPA is communicated to all members of the committee, especially those not in attendance at that time. The IDT addressed the acute care needs of the individual, but there was no information concerning a review of the week prior to the acute illness. Such factors as whether positioning was a concern, and whether there was adequate monitoring to ensure positioning, were just a couple of several aspects of care that were not addressed. ▪ **Infection control updates:** During the three morning meetings, there were two infection control updates presented. ▪ **Summaries of completed consultations:** During the three morning meetings, there were zero summaries presented of completed consultations from the prior	

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		day. It would not necessarily be expected that such discussions would occur daily. ▪ **Dental Department updates:** The Dental Department provided brief updates/information during zero of three medical morning meetings. It would not necessarily be expected that such discussions would occur daily. ▪ **PT/OT/ST and PNMT updates:** The PT, OT, ST and PNMT presented updates during zero of three morning meetings. It would not necessarily be expected that such discussions would occur daily. ▪ **Skin integrity updates:** Skin integrity (i.e., decubitus ulcer) reports/updates were provided at zero of three morning meetings. There were a number of skin integrity issues identified at the medical morning meeting, but these were related to potential infections and the Infection Control Nurse provided reports on these specific concerns. It would not necessarily be expected that such discussions would occur daily. ▪ **Discussion of significant weight change:** There was a discussion of individuals with significant weight loss or gain at zero of three (0%) medical morning meetings. ▪ **Hospital Liaison Nurse updates:** The Hospital Nurse Liaison reported an update for four of four (100%) hospitalizations during the observed meetings. ▪ **On-call PCP participation:** For the three meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in two of three (67%) meetings. A conflict of schedule did not allow one on-call PCP to present at the meeting, but the PCP made arrangements for the information to be discussed at the meeting. ▪ **Attending PCP participation:** Attending PCP participation/discussion (when not the on-call PCP) concerning an individual was documented in zero of three (0%) meeting minutes. It was observed that PCPs did participate in a number of discussions, but this was not recorded. Additionally, participation by other departments, when it occurred, was not recorded. The strengths noted at the morning meetings included the following: ▪ There appeared to be attendance by essential departments. ▪ There appeared to be a structure in place to follow events on campus, track ER visits and hospitalizations, as well as track ISPA completion. ▪ The submitted hospital liaison reports appeared to be thorough. However, they were handwritten. A typed copy as a part of the morning minutes would be helpful. Weakness and concerns noted at the morning meeting included the following: ▪ The Committee did not engage in the necessary critical clinical discussion necessary to ensure treatment was appropriate, and prevention was a focus.	

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		▪ The format was difficult to follow, especially the 24-hour log. Reversing the chronological order so that the most recent events are at the start of the list might assist. ▪ Assignments of record reviews for acute care visits to the hospital (admissions and specific types of ER visits) with clear due dates, review of contents of ISPAs at the morning meetings, and review of important consults at the morning meeting were indicated. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. Individuals newly admitted (within the prior 12 months) were omitted, because there would only be one annual exam/assessment completed. A list of 248 names was submitted with dates of the physical exam from 2011, dates of the summary from 2011, dates of the annual exam from 2012, and dates of the annual exam in 2013. It was noted that in 2011, the physical examination and the annual medical assessment were completed on different dates for some individuals. Removing six new admissions listed for the prior year, the total to be evaluated was 242 individuals. There were six data entries of typographical errors or use of a symbol without a key for interpretation. These were also removed, leaving 236 individuals to be evaluated. If a 2013 assessment date was entered, this was compared to the 2012 assessment date. If the last annual was in 2012 and not due until after 3/1/13, the prior 2011 summary date and 2011 physical date were compared to the 2012 annual assessment completion date. The 2012 annual assessment date was considered timely if within 365 days of both 2011 dates for the physical exam and the medical summary. Additionally, if the 2012 annual exam was in February 2012 or earlier, without evidence of a 2013 annual exam, this was considered overdue. Based on the above guidelines, 138 of 248 (56%) of annual assessments were timely. For 20 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. ▪ For the 20 individuals, compliance was 18 out of 20 (90%). ▪ For the 20 most recent annual medical assessments, there was an interval history included as part of the document in 20 of 20 (100%) reviews. ▪ For the 20 most recent annual medical assessments, the major active problems listed had action plans (lab testing, medication, etc.) addressing each of these problems in 20 of 20 assessments (100%). ▪ For the 20 most recent annual medical assessments, 18 of 20 (90%) addressed smoking history.	

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		▪ Family history was adequate/helpful in seven of 20 (35%). ▪ A discussion of appropriateness/requirements for transition to the community was included in 20 of 20 (100%). As part of the monitoring review process, the Monitoring Team selected the medical records of 19 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on the "At Risk Ratings" list, dated 4/1/13. Individuals were chosen with high-risk ratings in one or more risk groups/categories. All risk groups/categories were represented in the sample of 19 individuals. This methodology allowed the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included the preventive care flow sheet, physician orders for the prior year, integrated progress notes for the prior year, the most recent three quarterly medical reviews, the most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/ Computed Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, ultrasound scans, other radiographic test results for the prior year, the Integrated Risk Rating Form, the most recent health care management plan/risk action plan/Integrated Health Care Plan, the most recent annual medical assessment and physical exam, So Not Resuscitate (DNR) forms if applicable, the DG-1, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is discussed. From 19 medical records reviewed: ▪ Eighteen of 19 (95%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in four of 19 (21%). ▪ Sixteen of 19 (84%) had information about smoking history. ▪ A family history was documented, or attempts at obtaining this information had been made, in four of 19 (21%) records. ▪ Eighteen of 19 (95%) had information discussing requirements for transition. ▪ Of the 19 DG-1 forms reviewed, eight (42%) included all significant diagnoses. These 19 medical records also were reviewed to determine whether the physician IPN note used the Subjective, Objective, Assessment, and Plan (SOAP) format. ▪ In 19 of 19 (100%), the SOAP format was used. ▪ For 18 of 19 (95%), the time of the IPN was documented. ▪ For 15 of 19 (79%), vital signs were recorded.	

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		During the year, it was anticipated that three quarterly medical reviews would have been completed. The fourth quarterly review would be replaced by the annual exam. The last three quarterly medical reviews were requested. For the 19 records reviewed, 57 quarterly medical reviews should have been completed. Twenty-nine quarterly medical reviews were submitted (51%). The Facility submitted a series of documents entitled "Quarterlies Schedule" for each PCP, which provided a list of the dates of the quarterly medical reviews completed since the Monitoring Team's previous visit. There were 246 names listed for quarterly medical reviews from September 2012 through February 2013. For 246 names, one would estimate that 25 percent of these would have an annual medical evaluation to replace a quarterly medical review each quarter of the year. From this estimation, one would anticipate that a total of 184 (246 x .75) quarterly medical reviews should occur per quarter, or 368 in two quarters. The total number submitted for the two quarters was 172 (47%). This calculation did not account for those individuals no longer at the Facility due to transfer, transition, or those admitted in the prior six months. For each PCP, two of the most recently completed quarterly medical reviews from each assigned residence were requested. There were 10 quarterly medical reviews submitted and four PCPs completed the 10 quarterly medical reviews. ▪ A template format was used by four of the five PCPs. One PCP was not represented in the submitted documents. ▪ A template was utilized/completed in 10 of 10 (100%) of the quarterly medical reviews. ▪ Ten of 10 (100%) included the date of the quarterly review completion. ▪ Ten of 10 (100%) included the signature of the PCP. ▪ Major new diagnoses were listed in eight of eight (100%) of the medical quarterly reviews. ▪ The last three monthly weights or equivalent information were recorded in nine of 10 (90%) of the medical quarterly reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in seven of seven (100%) of the medical quarterly reviews. ▪ When a seizure disorder was present, the date of the most recent seizure was documented in six of seven (86%) of the medical quarterly reviews. ▪ There was documentation of changes in medication in six of seven (86%) of the medical quarterly reviews. ▪ Important/abnormal labs and drug levels/radiographic test results were documented in eight of eight (100%) of the medical quarterly reviews. ▪ For individuals that were hospitalized or had an ER visit, there was documentation of ER visits, and hospitalizations with dates and discharge diagnoses in six of six (100%) of the medical quarterly reviews.	

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		▪ There was documentation of important consultations completed in nine of nine (100%) of the medical quarterly reviews. ▪ There was documentation of results of consultations in four of nine (44%). <u>Access to Specialists</u> The following off-site appointments were scheduled/completed from 8/1/12 through 1/31/13 per specialty: ▪ Dermatology – 13 appointments scheduled, 11 appointments completed; ▪ Endocrinology – seven appointments scheduled, three appointments completed; ▪ ENT - 24 appointments scheduled, 17 appointments completed; ▪ Gynecology/Women's Health - 105 appointments scheduled, 68 appointments completed; ▪ Hematology/Oncology – 25 appointments scheduled, 13 appointments completed; ▪ Nephrology/Dialysis - 57 appointments scheduled, 53 appointments completed; ▪ Neurology – five appointments scheduled, three appointments completed; ▪ Ophthalmology – 151 appointments scheduled, 109 appointments completed; ▪ Oral Surgery - 14 appointments scheduled, 13 appointments completed; ▪ Orthopedics – 35 appointments scheduled, 22 appointments completed; ▪ Podiatry - 56 appointments scheduled, 37 appointments completed; ▪ Pulmonary - eight appointments scheduled, five appointments completed; ▪ Rheumatology – two appointments scheduled, two appointments completed; ▪ Surgery - 19 appointments scheduled, 16 appointments completed; and ▪ Urology – 51 appointments scheduled, 46 appointments completed. The total number of appointments completed, based on this information, was 404. The total number of appointments scheduled was 586. The completed appointment rate was 69 percent. On site, several specialty clinics were held to meet the needs of the individuals from 8/1/12 through 2/28/13. On site clinics occurred on the following dates: ▪ Ortho Clinic: October 2012 (11 completed appointments, no missed appointments) and January 2013 (10 completed appointments, five missed appointments). The completed appointment rate was 81 percent. It was noted that the five missed appointments were due to residence isolation. ▪ Neurology Clinic: August 2012 (15 completed appointments, no missed appointments), October 2012 (21 completed appointments, two missed appointments), and February 2013 (22 completed appointments, no missed appointments). The completed appointment rate was 97 percent. <u>The quality of the consultation referrals is reviewed as part of the peer review process.</u>	

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		This is discussed in further detail with regard to Sections L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed in Section G.2. <u>Missed appointments</u> Dates of missed medical appointments were provided for the period from 8/15/12 through 2/15/13. Missed appointments listed occurred in the following months: ▪ August 2012 – two; ▪ September 2012 – one; ▪ October 2012 – zero; ▪ November 2012 – two; ▪ December 2012 -seven; ▪ January 2013 – 17; and ▪ February 2012 – 10. From this information, it appeared that insufficient data was collected for missed appointments, especially for the time period from August 2012 through December 2012. Of the 39 missed appointments, 36 had follow up appointments scheduled. There was no information as to whether or not these had been completed. There were several individuals with more than one missed appointment for the original appointment. Of the appointments missed, 11 were due to refusals (28%). It is recommended that the Medical Department develop a tracking system of missed/no show appointments, including the type/specialty of appointment missed, the reason missed, the follow up rescheduled date, whether the rescheduled appointment was completed, and the number of days from the first appointment missed to the completed appointment. If there are serial missed appointments by an individual, there should be evidence of referral to the IDT and an ISPA to addresses the concern. The Medical Department submitted a second set of data tracking missed appointments and included subcategories of refused and missed appointments. Also tracked was whether refusals had a follow up appointment made and whether the appointment was completed. The data was submitted from May 2012 through January 2013. The early data numbers appeared low compared to the more recent data, suggesting the more recent data was complete and more reliable. For January 2013, there were 166 appointments made, and 104 completed (63%), which included higher numbers than the prior data set for January missed appointments. Four appointments were refused and 45 were missed for other reasons. Of these 49 appointments, 46 follow-up appointments were made. Completed follow up appointments were listed, but it was difficult to interpret if these were from the missed appointment list for that month or prior months.	

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		For two individuals with repeated refusals to attend appointments/complete diagnostic tests, the IDT met and developed ISPAs. For one individual, the team recommended to defer the diagnostic test (screening) for a year. It was not clear what was to occur in the meantime to attain the goal of a completed visit. Increased incentives were discussed for the other individual to attend appointments. Although this might be helpful for a general medical visit, how this would translate into compliance steps with completing the preparation needed for a colonoscopy was not clarified. <u>Preventive Care</u> ▪ Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in 19 out of 19 (100%) of the records reviewed. ▪ Preventive care flow sheets were updated in the prior 12 months in 18 of 19 (95%). ▪ Current information was included in five of 19 (26%) records reviewed. As an example of a lack of updating this document, many of these forms were updated at the time of the annual medical assessment in the first half of 2012, but they did not include the annual flu vaccine date, which was administered later in the year. ▪ The most recent vision screening was documented in 17 out of 19 (89%) records reviewed. ▪ The most recent audiological screening was recorded in 19 of 19 (100%) of the records reviewed. ▪ The influenza vaccination had been documented as administered in 16 of 19 (84%) of the individuals in a timely manner during 2012. o This was often not located on the preventive care flow sheet. For one individual, there had been a history of refusing to cooperate in flu vaccine administration. For two individuals, no information could be located in the record (e.g., preventive care flow sheet, IPNs, nursing assessments submitted, etc.) that this vaccine had been administered. ▪ Whether an individual received a hepatitis B vaccine or had an immune status (positive or negative) determined by history or laboratory work was recorded in 19 of the 19 (100%) of the active records reviewed. However, there were instances of antibodies [2 of 19 (11%)] being nonreactive, and no further notation. It appeared that a series had been given more than once in the past, and the individual continued to not have antibodies, but there was no information from the submitted documents to confirm that the series had been given. It is recommended that if an individual has been vaccinated in the past, the dates of vaccination, along with the immune status be maintained in the record on the preventive care flow sheet. This might also be documented in the annual medical assessment. Currently, if the record is thinned, this information may no longer be available. Additionally, there was one of 19 (5%) with a	

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		discrepancy in the history, stating there was immunity on the preventive care flow sheet, but the annual medical assessment indicated there was no antibody reaction on testing. Due to these gaps in important information and conflicting information, compliance was considered 16 of 19 (84%). ▪ Varicella immunity or vaccination was documented in 19 of 19 (100%) reviews. ▪ A pneumococcal vaccination had been given to 19 of 19 (100%) individuals. ▪ A zoster vaccination had been given to six of eight (75%) eligible individuals. ▪ A Tdap had been given to seven of 19 (37%) individuals. It is recommended that the Facility follow CDC and local county health department guidelines in determining a schedule for Tdap, pneumovax, PCV13, and other vaccinations for eligible individuals residing at CCSSLC. It is recommended that a policy for updating the vaccination schedule be developed and implemented, reflecting the CDC guidelines. *Mammograms* A list was submitted indicating women residing at CCSSLC who were over the age of 40, along with the date of last mammogram, and, if applicable, the reason it was not done or was outdated. A total of 96 women were identified as being over the age of 40. Of these, there were two women aged 70 or greater. The DADS SSLCs policy "Preventive Health Care Guidelines", dated 8/30/11 was to be followed. Of these 94 women in the eligible age range, 17 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 77 women, 74 had mammograms within the prior year. This was a compliance rate of 74 out of 77 (96%). Three individuals refused to cooperate for a mammogram. There was a note entered for one on the submitted documents, which indicated, "look for ISPA." One would expect an ISPA for all three refusals. Of the two women over the age of 70, one had a clinical reason for not completing a mammogram and the other had a mammogram completed. From the sample of 19 medical records reviewed, there were eight females between the ages of 40 and 70. Of these, seven females were eligible for a yearly mammogram (i.e., no contraindication or reason for not completing a mammogram). Seven of seven (100%) were up-to-date on mammogram testing. *Pap smears* From the sample of 19 active records reviewed, there were eight females between the ages of 21 and 65. Seven of eight females (88%) did not meet criteria/have risk factors that necessitated pap smear testing in the prior three years. Zero females (0%) had a pap smear completed within the prior three years. This was a compliance rate of zero (0%).	

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		The Facility had developed a database to monitor preventive aspects of women's health, including pelvic exams and pap smears. A list of women ages 21 to 65 was submitted, with the date of pap smear, whether the pap smear was considered an adequate specimen, whether a pelvic exam was completed, history of hysterectomy and reason for this if applicable, and other reasons if pap or pelvic exam not completed. The list included information for 103 women. The date of the most recent pap smear was recorded. There were 20 women that had a pap smear completed between 2010 and 2013. Three had pap smears in 2012 for disease entities and these were not considered screening tests. There were 17 women that had a pap smear completed between 2010 and 2013 for screening reasons. There were seven individuals that had the most recent pap smear completed from 2005 to 2009. There were 25 individuals that had the most recent pap smear completed from 2000 to 2004. There were 11 individuals that had the most recent pap smear completed from 1990 to 1999. There were three individuals that had the most recent pap smear completed prior to 1990. For 25 individuals, it was not determined when the last pap smear might have occurred. Eight individuals had hysterectomies (but not all were for benign pathology). Reasons for not completing a pelvic exam included: "not sexually active," "asymptomatic," and "not high risk/human papilloma virus." Reasons for not completing a pap smear included: "not sexually active," and "never sexually active." That 20 of 103 (19%) had completed pap smears in the prior three years suggested the need for further policy review and assistance from the State Office to determine the needed indicators in deciding whether a pap and pelvic exam should be part of the routine preventive care of the individual and the frequency of testing/examination. That there was no information for 25 (24%) individuals indicated the need for a process in ensuring a gynecologic history is obtained on admission and retained in the active record. *Colonoscopy preventive screening* The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, and the reason for the colonoscopy. A total of 131 names were submitted. Of these, three were over the age of 75, and for six there was incomplete data or data entry irregularities which meant they could not be further included in the data. Of the 131, seven of these had clinical contraindications or family/guardian refusals of consent. Therefore, the eligible population for screening colonoscopy was 115 individuals. Of these 115, 35 had colonoscopies in the prior 10 years for medical concerns and were not defined as preventive testing. The remaining eligible population for screening colonoscopy was 80. Of this population 78 (98%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Three of the three (100%) individuals for whom a colonoscopy or clinical alternative was indicated after the age of 75 had completed an appropriate procedure within the prior 10 years. Two as a preventive test	

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		(67%) and one (33%) as a diagnostic test for an active problem. Of the 19 active records reviewed, there were 10 individuals from the age of 50 to 75 and two were over the age of 75. None had a clinical reason for not pursuing a colonoscopy. Of the individuals for whom colonoscopy screening was indicated, nine of 10 (90%) had a colonoscopy completed in the past 10 years. For the two individuals greater than 75, both (100%) had a colonoscopy in the prior 10 years. *Osteopenia/Osteoporosis* A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses was also requested. Additionally, for all individuals over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. This information was requested, because for those with a diagnosis of osteopenia or osteoporosis, a T-score usually would be an important aspect of the work-up provided through a DEXA scan. Additionally, based on the T-score, treatment would be ordered to optimally treat the individual. Follow up DEXAs to determine T-scores are indicated at intervals (every two - three years) to determine effectiveness of treatment. A total of 105 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. ▪ Of the 105 individuals reviewed, the T-scores were interpreted as normal in none. All had a T-score consistent with osteoporosis or osteopenia. Seven were considered to have osteopenia and 98 were considered to have osteoporosis. o All of the 105 (100%) DEXA scans were considered current (completed within the prior three years). o Seven of seven (100%) with osteopenia were treated with a bisphosphonate or alternative medication to treat osteopenia or prevent osteoporosis. o 88 of 98 (90%) with osteoporosis were treated with a bisphosphonate or alternative medication for osteoporosis. o One hundred of 105 (95%) were treated with calcium supplementation. o One hundred one of 105 (96%) were treated with Vitamin D supplementation. Ruling out secondary causes of osteopenia or osteoporosis are part of the evaluation in the etiology and treatment of this diagnosis. Although some causes may be obvious, such as antiepileptic drug side effects, or lifelong non-ambulatory status, treatment might not be effective unless contributing causes are also identified and treated. ▪ For men with osteopenia/osteoporosis, lab testing for secondary causes was submitted. Forty-four men were identified with osteopenia/osteoporosis.	

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		o Two of 44 (5%) had a biochemical profiles submitted. o Three of 44 (7%) had thyroid lab testing submitted. o None of 44 (0%) had a sedimentation rate or equivalent lab test submitted. o Thirty-three of 44 (75%) had a Complete Blood Count (CBC) submitted. o Forty-three of 44 (98%) had a Vitamin D level submitted. o Two of 44 (5%) had hormonal testing for hypogonadism submitted. o Eighteen of 44 also had antiepileptic drug levels submitted, indicating a potential contributing cause for osteopenia/osteoporosis. ▪ Sixty-one women were identified with osteopenia/osteoporosis. o Three of 61 (5%) had a biochemical profile submitted. o Nine of 61 (15%) had thyroid lab testing submitted. o Zero of 61 (0%) had a sedimentation rate or equivalent lab test submitted. o Fifty-three of 61 (87%) had a CBC submitted. o Sixty-one of 61 (100%) had a Vitamin D level submitted. o Two of 61 (3%) had testing of Luteinizing hormone (LH) and follicle-stimulating hormone (FSH). For the secondary causes of osteopenia or osteoporosis, it is likely that some of these lab tests were completed, but not submitted (e.g., such as the biochemical profile). Further comment cannot be made on the lack of lab testing. Additionally, the clinical guideline/pathway distributed by the State Office did not appear to provide a standardized approach to the evaluation of secondary causes of osteopenia/osteoporosis. An additional addendum to the osteoporosis policy outlining a standardized set of lab tests to ensure recognition/presence of additional secondary causes of this disease would provide guidance to the PCPs. To determine an assessment of calculation of daily calcium and Vitamin D intake for each individual with a diagnosis of osteopenia/osteoporosis, nutritional evaluations were submitted for 105 individuals with this diagnosis. ▪ Five of 105 (5%) included the diagnosis of osteopenia/osteoporosis in the evaluation. o Forty of 105 (38%) included a calculation of average calcium intake per day. o Of these, there were 15 individuals with low calcium dietary intake, but zero of the 15 (0%) had additional recommendations or review of supplements that could have been ordered to ensure adequate intake. These 15 individuals had calcium intake below the daily requirements	

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		for osteopenia/osteoporosis treatment and prevention, but there was no recommendation based on this information. o There was one of 105 (0.9%) individuals with a calculation of Vitamin D intake per day. Based on this information, the dietary department should consider updating the diagnoses in the nutritional evaluations. When an individual has a diagnosis of osteopenia/osteoporosis, precise recommendations based on calcium and Vitamin D intake calculations should be made, commenting also on whether any supplements are adequate to meet the needs of the individual. The clinical pathway/guideline for osteoporosis did state the minimum requirements for these nutritional elements, which would assist the dietary department. It is recommended that the State Office provide updates to the clinical pathway/guideline concerning calcium and Vitamin D requirements for adults that reflect current national standards as changes occur. Additionally, reviewing the Vitamin D level in the document and responding with additional recommendations as applicable would guide the PCP and IDT in optimizing treatment. From the sample of 19 medical records reviewed, 15 (79%) had a diagnosis of osteopenia or osteoporosis and all 15 (100%) had completed a DEXA scan. All 15 of 15 (100%) of these DEXA scans were completed within the prior three years. ▪ Of these, 15 of 15 (100%) had a DEXA scan /T-score recorded. ▪ Of these, 15 of 15 (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia. ▪ Of these, 15 of 15 (100%) had been prescribed supplemental calcium. ▪ Of these, 15 of 15 (100%) had been prescribed Vitamin D. ▪ Of these, nine of 15 (60%) had a bisphosphonate ordered. ▪ Of these, six of 15 (40%) had Miacalcin ordered. *Down Syndrome* An undated list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 11 individuals were identified with a diagnosis of Down syndrome. Eleven of 11 (100%) had a thyroid test completed from March 2012 to December 2012. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room (ER) and returned. These individuals are listed in the documents reviewed section. Ten of the 10 had gone to the ER from their residence. None of the 10 had gone from the Infirmary to the ER. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified prior to the	

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		arrival of the individual with appropriate medical background information for seven of 10 (70%) records reviewed. ▪ Prior to the transfer to the ER, a PCP was on site for one of these transfers. In one of one (100%) record, the PCP had written an IPN that included the date and time. ▪ For zero of one (0%) PCP transfer IPNs, the vital signs were recorded. ▪ For one of one (100%) PCP transfer IPNs, the reason for the transfer was documented. ▪ In zero of one (0%) PCP transfer IPNs, the SOAP format was utilized. ▪ A copy of the ER report/ER labs was available in three of 10 (30%). ▪ Of the 10 ER visits, diagnostic categories included: trauma (six), gastrointestinal (two), neurological (one), and cardiovascular (one). ▪ When the individual returned to the Facility after evaluation at the ER, 10 of the 10 active records (100%) had a PCP IPN. ▪ Ten of 10 (100%) post ER visit PCP IPNs included date and time. ▪ Eight of 10 (80%) post ER visit PCP IPNs included recording of vital signs. ▪ Nine of 10 (90%) post ER visit PCP IPNs utilized a SOAP format. ▪ A summary of ER information and findings was included in 10 of 10 (100%) PCP IPNs. ▪ When returning to the Facility, eight returned to the individual's residence, and two returned to the Infirmary. ▪ Nine of the 10 records (90%) had additional PCP IPNs as follow-up to the original concern. ▪ For 10 of 10 (100%), treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER. Additionally, 10 active records were reviewed for those individuals admitted to the hospital. Ten individuals returned to the Facility. None of 10 of the individuals died while in the hospital. The following provide the results of this review: ▪ Ten of 10 (100%) had PCP IPNs post hospitalization. ▪ Of the 10 post hospital PCP IPNs submitted, eight of 10 (80%) included vital signs or documented attempts at vital signs. ▪ Ten of 10 (100%) post hospital PCP IPNs included date and time. ▪ Nine of 10 (90%) post hospital PCP IPNs had an adequate summary of hospital events and findings. ▪ Ten of 10 (100%) post hospital PCP IPNs used the SOAP format. ▪ Nine of 10 (90%) active records of the hospitalized individuals included a copy of the hospital admission history and physical. ▪ Seven of 10 (70%) active records included a copy of the hospital discharge summary. ▪ Ten of 10 (100%) active records included a copy of either the hospital admission	

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		history or physical, or a copy of the hospital discharge summary. ▪ Ten of the 10 (100%) included Hospital Liaison Nurse notes for the individuals. ▪ For seven (70%) of the individuals that returned to the Facility, additional PCP IPNs were included as part of the follow-up. ▪ Of the 10 hospitalizations, major organ system categories/reasons for the hospitalizations included the following: o Infection - two; o Respiratory – two; o Trauma – two; o Gastrointestinal – three; and o Neurological – one. CCSSLC did have an Infirmary. The admissions of individuals to the Infirmary during the prior six months was as follows: ▪ The length of stay varied from less than one day to 83 days. ▪ From 8/1/12 through 1/31/13, the average length of stay was 9.89 days for 100 admissions to the Infirmary that had been discharged. ▪ The number staying less than one day was two. ▪ The number staying one day was 24. ▪ The number staying two days was eight. ▪ The number staying three days was nine. ▪ The number staying four days was nine. ▪ The number staying five days was four. ▪ The number staying six days was one. ▪ The number staying seven to 10 days was 12. ▪ The number staying 11 to 20 days was 16. ▪ The number staying 21 to 30 days was eight. ▪ The number staying 31 to 60 days was five. ▪ The number staying 61 or more days was two. There were 104 admissions to the Infirmary during this time. The length of stay was not determined for four individuals, because these individuals still resided in the Infirmary as of 1/31/13. It was noted these four admissions were all admitted during January 2013. *Pneumonia* Data was submitted which had been entered into the Avatar database. Information concerning pneumonias was submitted for the time period of August 1, 2012 through January 31, 2013. According to this database, there were 20 pneumonias during this time period. Of these 20, three (15%) were categorized as aspiration pneumonia. Off-site physicians diagnosed fourteen (70%) of these 20 pneumonias. For none of the 20	

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		(0%), the location at the time of the diagnosis (i.e., hospital, home, furlough, etc.) was provided. As part of confirmation of the diagnosis of pneumonia, the following information was provided in this database. ▪ Twenty of 20 (100%) had a chest x-ray completed. For seven of the 20 (35%), data submitted indicated blood cultures were obtained. Blood cultures were negative in seven of seven (100%). Sputum culture was reported to have been positive in five of six (83%) cases. In summary, it was determined that supportive evidence was found for the diagnosis of pneumonia for 20 of 20 (100%). ▪ According to the database, seven of the 20 (35%) individuals were taking nutrition by mouth at the time of the pneumonia. o For six of seven (86%), there was documentation of a therapeutic diet with varying textures and fluid thickenings. ▪ Fourteen of the 20 (70%) individuals had a feeding tube prior to the onset of the pneumonia. o It was noted that one person had a feeding tube and also took food by mouth. o Twelve of the 14 (86%) had gastrostomy tubes, one (7%) had both a gastrostomy and jejunostomy tube, none (0%) had a gastrojejunostomy tube, and one (7%) had a jejunostomy tubes. o The formula flow rate for those with jejunostomy tubes was continuous in one of two. o For those with gastrostomy tubes, five utilized an intermittent flow rate, and seven utilized bolus feedings. ▪ Avatar documented that one of the three with supportive evidence of aspiration pneumonia underwent a modified barium swallow study shortly after the diagnosis of aspiration pneumonia. From a different database entitled "Individuals Diagnosed with Pneumonia between 1/1/12-1/31/13," printed 2/18/13, the number of pneumonia cases per month was listed as follows: ▪ August 2012 - two; ▪ September 2012 – one; ▪ October 2012 – four; ▪ November 2012 – three; ▪ December 2012 – 10; and ▪ January 2012 - one. It was noted that the Avatar database included nine pneumonia cases for December 2012. This database documented 10 pneumonias. The additional case was an individual that had aspiration pneumonia. This same individual was also listed in the database	

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		submitted by the Infection Control Nurse in quarterly data from November 2012 to January 2013. The chart entitled "CCSSLC Client Information – Infections and Immunizations," submitted to the Infection Control Committee of 12/4/12, indicated that there were two pneumonias in September 2012, which was not in agreement with the other databases. The reason for the discrepancies in these three databases compared to the Avatar database was not clear. *Other acute conditions* Information concerning a diagnosis of sepsis was provided through a series of charts, entitled as follows: ▪ "CCSSLC Sepsis Diagnoses 11/1/11 to 10/31/12;" ▪ "ER visits 1/1/12 to 1/31/13 with admit diagnosis of sepsis;" ▪ "Hospital Admissions 1/1/12 to 1/31/13 with admit diagnosis of sepsis;" and ▪ "Hospital Admissions 1/1/12 to 1/31/13 with discharge diagnosis of sepsis." Based on information from 8/1/12 through 1/31/13 (i.e., a six-month period), six individuals had sepsis. One individual had sepsis three different times. *Trauma* During the time period from June 2012 through January 2013, there were 12 fractures, according to a document entitled "Fractures," which was undated. There were three events in which more than one fracture occurred. The fracture site included the following: ▪ Lower extremity – six individuals (for one individual, the information did not include confirmation of a fracture); ▪ Upper extremity – three individuals; ▪ Nose – two individuals; and ▪ Cervical spine – one individual. During the time period from October 2012 through January 2013, there were four individuals that went to the ER or were hospitalized for injuries. <u>Chronic Conditions and Specific Diagnostic Categories</u> *GERD* As part of the review of 19 records, GERD was reviewed. Of the 19, 12 (63%) of the individuals were diagnosed with GERD. For the following, not each case would have had the listed test or procedure, but provides evidence of the spectrum of treatment at the Facility: ▪ Of these 12, an esophagogastroduodenoscopy (EGD), gastroscopy, or upper gastrointestinal (UGI) had been completed for six (50%). ▪ Of these 12, two (17%) had a fundoplication.	

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		▪ Of these 12, five (42%) had a feeding tube. ▪ Of these 12, 12 (100%) had appropriate medication prescribed. ▪ Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in 12 of 12 (100%) reviews. *Newly diagnosed Chronic conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. There was no information submitted indicating the number of individuals that were newly diagnosed with Diabetes Mellitus Type II. There was no information submitted indicating the number of individuals that were newly diagnosed with cardiovascular disease. One individual was newly diagnosed with cancer since the Monitoring Team's prior visit. *Pica* An updated and complete list of pica or ingestion of inedible objects/liquids was submitted for the time period of August 2012 through November 2012. This included 13 events involving nine individuals. Two pica incidents required an ER visit or hospitalization. One individual had three pica events, and two individuals had two pica events each. *Chronic constipation* Two separate, undated lists were submitted for individuals with a diagnosis or risk of constipation. One was entitled "List of residents taking at least one medication for the indication of constipation or constipation prophylaxis." This list identified 192 individuals who were taking medication for constipation or constipation prevention. The other list was untitled, but appeared to have been generated from the at risk list of those with medium and high risk for constipation. This list identified 187 individuals as being at medium or high risk of constipation. According to data submitted, five individuals required admission to the hospital for treatment of bowel obstruction or bowel perforation/complication from 8/1/12 through 1/14/13. Two individuals each had two admissions for bowel obstruction/bowel perforation. From a document entitled "Individuals Diagnosis of Small Bowel Obstruction," there were six events of small bowel obstruction listed from August 2012 through January 2013. For the prior six months, February 2012 through July 2012, there was one event of small bowel obstruction. It is recommended that a review of bowel movement records and bowel management be completed for individuals that are sent to the ER or hospitalized for small bowel obstruction. This would include a review of early warning signs of abdominal pain or discomfort or constipation, including subtle gestures or	

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		sounds that indicate to staff that a concern needs to be addressed. A review of medication that contributes to constipation should be reviewed by Pharmacy, and the combination and dosage of anti-constipation medications should be optimized. Although there are many causes of small bowel obstruction, it is important to prevent treatable concerns that may aggravate or cause this problem. *Enteral feeding tubes* The Facility submitted information that six individuals were identified as having jejunostomy tubes or gastro-jejunostomy tubes. A review of the medication profiles was completed to determine whether medications not recommended for administration through these specific tubes were ordered (e.g., Quinolones, Sucralfate, Anatacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for six of six (100%) individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. *Skin Integrity* The Skin Integrity Committee met on 1/2/13 (rescheduled from 12/20/12). Minutes were submitted for this one meeting in the past 12 months. It did not appear that there were prior or subsequent meetings of this committee, although an attendance tracking system indicated there had been two meetings in the prior six months. The meeting minutes indicated a meeting was scheduled for March 2013, but no minutes were submitted. In the meeting minutes of 1/2/13, six pressure sores were documented. Two occurred in September 2012, one occurred in October 2012, one occurred in November 2012, and two occurred in December 2012. Four originated in the residence, and two originated at the hospital. Five were stage II, and one was stage I. A "Pressure Ulcer Report" indicated that the two pressure ulcers from September had healed. One in December had healed. There remained three, according to the report, as of the end of December 2012. One individual died of unrelated issues. There was no follow-up information to determine the status of the remaining two individuals with decubiti. As a comparison, for the prior six months (February 2012 to July 2012), there were nine decubiti, versus six during this six-month interval from August 2012 to January 2013. It was noted that three of the six occurred on the buttocks, and two of the six occurred on the coccyx. This suggested the need to review preventive plans and monitoring of plans to ensure they are being carried out correctly. Ulcers in these areas of the body should generate a care plan that reflects many aspects of health care, including frequent repositioning, daily observation of skin integrity, nutritional status, and a review of the type and condition of the chairs and wheelchair used by these individuals. Maintenance schedules might need to be reviewed. A review to determine the need to revise the seating/cushions/molded parts to protect and enhance the posture of the individuals might be indicated.	

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		Seizure management A submitted document entitled "Individuals diagnosed with seizure disorders and receiving anticonvulsants" listed 153 individuals that had a diagnosis of a seizure disorder as of 2/3/13. Of these, 10 were not prescribed anti-epileptic drugs (AEDs). The Facility submitted a separate document with information concerning antiepileptic medication usage, entitled "Percentage of individuals on 1 or more AEDs." According to this document, there were 162 individuals listed as having been prescribed AEDs or having a diagnosis of seizures, but not prescribed AEDs. The date of this document was 2/25/13. Of these 162 individuals, 26 (16%) were prescribed no AED. Sixty-one (38%) were prescribed one antiepileptic medication, 36 (22%) were prescribed two antiepileptic medications, 23 (14%) were prescribed three antiepileptic medications, 10 (6%) were prescribed four antiepileptic medications, five (3%) were prescribed five antiepileptic medications, and one (0.6%) was prescribed six antiepileptic medications. Four individuals were considered to have a refractory seizure disorder. In the prior six months, two individuals were sent to the ER for an uncontrolled/ prolonged/new onset seizure. Seven individuals had status epilepticus during the time period July 2012 to January 2013. Two individuals had status epilepticus twice during this time period, for a total of nine status epilepticus events during this time period. An undated separate document entitled, "Individuals with a diagnosis of seizure disorder on no antiepileptic medications" documented 24 individuals in this category. A list, dated 2/15/13, was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. The denominator was the number of individuals on anti-epileptic medications at the time of the data collection/submission. Of the 160 individuals listed, 25 (16%) were prescribed Dilantin, none (0%) were prescribed Primidone, three (2%) were prescribed Phenobarbital, and none (0%) were prescribed Felbamate. Additionally, nine individuals had a VNS implant. Neurology clinics were held at the Facility on 8/18/12 and 10/20/12. At the 8/18/12 neurology clinic, 15 individuals completed appointments. At the 10/20/12 neurology clinic, 20 individuals completed appointments. Three individuals scheduled for appointments did not attend the neurology clinic.	

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		The Facility submitted documentation of seizure management, including neurology consultation notes for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records: ▪ For only one individual (Individual #340) was a neurology consult submitted for a seizure disorder. ▪ For one individual (Individual #287), a consult of 4/28/12 was submitted in which the neurologist was asked to review an order for an electromyography (EMG) (but may not have seen the individual at that time). The last consult for the seizure disorder might have been 3/31/12, but it was not submitted. ▪ One individual (Individual #325) chosen for the sample of five did not appear to have had an active seizure disorder and there was no mention of neurology consult in the documents submitted. There was a history of remote seizures, but the medications listed did not include a medication that was given for a seizure disorder. The reason for choosing this individual for review of seizure management was unclear, as a seizure disorder was not even listed as a risk for the individual. ▪ The submitted documents for this request included selected parts of the active medical record, and included a portion of IPNs that focused on seizure description, nursing assessments, and a seizure record for some of the seizures observed and documented. This did not provide evidence of communication of information to the neurologist, nor provide consult reports written by the neurologist. ▪ One of the individuals had been under good control of seizure activity (i.e., none recorded since January 2010) when last seen by the neurologist on 3/31/12 (Individual #287), but then had seizures on 7/6/12 and 9/12/12 with no submitted information as to whether this was discussed to determine additional steps to be taken by the PCP, nursing staff, or whether the neurologist was notified of the change in seizure pattern. ▪ It was noted that the seizure disorder flow sheet was not completed in a standard format for Individual #294, and the "Accumulative Yearly Seizure Record" was last completed in 2010, neither of which provided evidence of quality seizure management. This individual required Diastat on 8/2/12. There might have been an association of seizure activity and constipation and/or hypothermia, but the submitted documents did not provide evidence of an aggressive approach to reduce these comorbid conditions. ▪ For one individual (Individual #70), although no consult report was submitted, the individual was last seen on 6/23/12, and was to be seen in six months, but no further consult report was submitted as of the time of the Monitoring Team's visit. This suggested the consult was considerably overdue in an individual that also required Diastat and had an increase in medication in the last review.	

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		The Facility submitted information indicating that there were two neurology clinics on site for which 35 individuals attended. Considering the number of individuals with seizure disorders, as well as the individuals having had status epilepticus, a history of refractory seizures, or ER visits due to seizures, the Medical Director might need to further review the number of hours available for neurology consultation to determine if more hours, and/or further on-site clinics or off-site consultations are needed. It appeared the Facility did not have a tracking system for seizures that was consistent across campus, provided updated information in the active medical record rapidly, and ensured the neurology consultants received complete and timely information on individuals seen, along with a system to ensure communication between the Facility and the neurology consultants for changes in neurological conditions or changes in seizure activity. The active record needs to clearly indicate quality management of seizure disorders by the Facility. The submitted documentation should be reviewed before submission to ensure it includes the appropriate documentation. The Facility reported that there was no seizure management committee at CCSSLC. Considering the number of individuals with seizures and those with refractory seizures, prolonged seizures, and those sent to the ER for seizures, a committee to provide oversight of seizure management should be considered to review training, accuracy of documentation of seizures, seizure log completion, and system monitoring of seizure management (i.e., identification of both strengths and needs). <u>Do Not Resuscitate Orders</u> A total of 22 individuals at the Facility had DNR orders in place. The date of the original DNR decision was not submitted. Current annual review had been completed in 22 of 22 (100%) DNR decisions. Clinical justification was submitted for 0 of 22 (0%) DNR orders. There were no additional notes or orders for any DNRs or rescinding of DNRs submitted. While the Monitoring Team was on-site, there were two individuals hospitalized, both of whom needed decisions concerning end of life care. However, neither individual had guardians, placing burden of decision making on the hospital system. When there is a lack of guardians, end of life decisions are often then made by those who do not know the individuals. As required by Section U of the Settlement Agreement, the Facility's list of individuals requiring guardians should prioritize those who are at risk for rapid decline in health and who would benefit from a guardian. As also required by Section U, the Facility should have a plan for obtaining guardians for those that need them, particularly a system in which guardians are obtained for those who will need to have important life decisions made on their behalf. The Facility Ethics Committee met on 10/26/12 to discuss a specific individual to review	

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		DNR status. The minutes of the 10/26/12 meeting included attendance (20 names listed, including facility staff, family members, and the community physician via telephone). A brief clinical review was included, followed by an update and discussion concerning DNR status. The minutes clearly reflected the decision of the committee that the individual did not need DNR at that time. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of 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.	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review in December 2012 (Round #6). The following represents a synopsis of the information: ▪ For the one external peer review dated December 2012, PCP compliance in essential areas could not be determined, because the QA Department did not submit the audit questions and responses sorted by the essential areas. For areas considered nonessential, the QA Department did not submit the audit questions and responses sorted by the nonessential areas. ▪ The general external audit review process information did not indicate the number of records chosen for review. At the audit exit, the external medical peer reviewer documented that 22 records had been completed, but it appeared to be the only place where this information was located. ▪ The external audit review process information did indicate how the sample was obtained. ▪ Areas that appeared to need improvement from the external peer review were not listed or prioritized according to the indicators most frequently identified as deficient. ▪ Areas that appeared to need improvement from the external peer review included answers to the following audit questions: (2) Is the Active Problem list dated and signed when it was last reviewed? (3) Is there evidence that the Active Problem list was updated with each new problem or as problems were resolved? (9) Have the appropriate immunizations been given? (17) Are medically appropriate diagnostic tests and/or therapeutic procedures ordered? (18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? (20) Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow up documented in the integrated progress note? ▪ From the external peer review audit, there were 390 corrective action plans tabulated, according to a printout submitted. However, reviewing the supporting evidence indicated that this number appeared to be all the questions	Noncompliance

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		reviewed, and data concerning the findings of the auditors had not been entered into the database. From the individual PCP list of audit indicators needing review, there were 14 corrective action plans. From an alternative source providing analysis between audit rounds, it appeared there were eight corrective action plans needed. There was no follow-up information to determine whether these corrective action plans had been completed. ▪ In December 2012, an external medical management audit for Round #6 also was completed. The three areas of clinical focus were: Constipation, Seizures, and Urinary Tract Infections (UTIs). ▪ Areas that required improvement from the external medical management peer review were not listed or prioritized according to the indicators most frequently identified as deficient. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit indicator questions: o For Constipation: (1) Is constipation listed on the active problem list? o For Seizures: (1) Seizures are listed on the active problem list? (4) Quarterly review of seizures documented by the PCP with recommendations? o For Urinary Tract Infections: (1) Is urinary tract infection listed on the active problem list? ▪ From the external medical management audit for Round # 6, there were four corrective action plans generated. ▪ A follow-up QA review indicated there were two action plans that remained incomplete. The date of this updated information was not indicated. ▪ The external reviewer provided the Facility with a summary of the review, but without aggregate data representing their findings. ▪ The information that a Medical Provider Exit Interview was conducted for the December 2012 audit was located in the Presentation Book, but not with the audit folders submitted. From the external auditor review, there was preliminary information indicating areas of need and areas of strength. ▪ The QA Department did not calculate compliance rates, either per individual PCP, or per department. ▪ There was no analysis for compliance per question across each PCP's clinical practices. There was no review of audit results to determine the most common areas of noncompliance, which might need additional focus. This information would be valuable to the Medical Director in guiding the medical staff. ▪ Additionally, each PCP was not tracked for compliance in essential and nonessential elements. The chart provided indicated "Essential and Non-essential compliance" and another chart indicated "Essential elements compliance by care provider," but the system of essential and nonessential areas	

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		did not apply to the medical management audit to which the chart referred. ▪ A follow-up system was not implemented to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. For the external medical management peer review, there did appear to be one QA Department follow-up audit, but no further audit to ensure the remaining incomplete corrective action plans were resolved. There was no information concerning follow-up of the external general medical peer review audit. ▪ The QA Department did not compile compliance data with corrective action plans. ▪ The QA Department did not track corrective action plan resolution every 30 days until resolution. For the one follow-up external medical management audit corrective action plan, there was no date of the follow-up indicated. ▪ At the time of the Monitoring Team visit, for Round #6 from December 2012, for the 14 corrective action plans identified by the external medical peer review, there remained no information as to whether any had been corrected. ▪ The Medical Department did not provide staff meeting minutes that documented a discussion of the results of the external peer review results. ▪ The Medical Department did not provide staff meeting minutes that documented implementation steps to correct the deficiencies noted in the external peer review audits. ▪ The Medical Department did not provide staff meeting minutes that documented a discussion of systemic improvements to be developed and implemented to reduce deficiencies noted in the external peer review findings. ▪ It appeared that the QA Department needed further guidance in the Department's role in the process and documentation of the process. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death review for deaths that occurred more than 30 days before the Monitoring Team's visit. Since the last review of deaths during the Monitoring Team's last visit, eight deaths had occurred: ▪ The average age was 59 (varied from 37 to 71). ▪ Five individuals died under the age of 65, and three died at age 65 or greater. ▪ Of the deaths, four were females, and four were males. ▪ The causes of death were categorized based on a review of the following submitted information from the active record: o Sepsis – two; o Complications of acute asphyxiation – one; o Failure to thrive /medical complications of cerebral palsy – two; o Respiratory failure – one; o Post operative death – one; and o Cardiovascular disease – one.	

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		▪ Documentation indicated that an internal and external autopsy was completed in two deaths. An external exam only was completed for two. For one individual, autopsy completion could not be determined based on submitted information. ▪ DNR status was ordered while residing at CCSSLC for four of the eight, and ordered for five while in the hospital as determined by the hospital medical team and hospital administrative process. ▪ Five of eight died in a hospital setting. Three of eight died at the Facility. None died at another site. ▪ Six of eight (75%) had prior hospitalizations within 12 months prior to death. ▪ Four of eight (50%) had been hospitalized previously within four months of death. ▪ Four of eight (50%) had a feeding tube. ▪ Eight of eight (100%) included documentation indicating they were aggressively treated immediately prior to their deaths, or aggressively treated until a decision of DNR was made. ▪ One of eight (13%) was enrolled in hospice. ▪ Three of eight (38%) were considered ambulatory (either independently or with assistance). Five of eight (63%) were considered non-ambulatory. ▪ Zero of eight (0%) clinical death reviews occurred and summaries were available within 14 days of the death. Time from date of death to the date of the clinical death review summary varied from 16 to 36 days. ▪ One of eight (13%) administrative death reviews occurred within 28 days of the clinical death review. ▪ For the eight clinical death reviews, there were 11 recommendations. Two reviews had three recommendations each. Five reviews had one recommendation each. One review had no recommendation. Clinical death review recommendations and nursing QI death review recommendations were discussed at the administrative death reviews. The administrative death reviews recorded the final list of recommendations for the death review process of the individual. ▪ For the eight administrative death reviews, there were 15 recommendations. Two reviews had five recommendations. One review had three recommendations. One review had two recommendations. Four reviews had no recommendations. It was noted that there were clinical death reviews with recommendations that were not reflected in administrative death review recommendations. There was no information whether these had any follow up by any of the clinical departments. It was not clear from the administrative death review the rationale for not including them in the administrative death review recommendations, as there were no minutes of the content of discussion at these meetings.	

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		▪ Further, there was only one recommendation with a partial follow-up response to a recommendation. This was a focused in-service, but did not lead to any systemic change in policy/procedure or monitoring policy/procedure to ensure changes had been made. This response was inadequate for the systemic needs of the Facility. ▪ For the other 14 recommendations, there was no follow-up information available. The Facility is encouraged to follow up on these recommendations as a priority. In Section I.3, examples are provided of ongoing concerns of those at risk. It appeared there was no process in place to follow up on any of these recommendations, or to monitor implementation of any recommendations to ensure this was an area of ongoing improvement. The Facility had identified this as a need, and was in the process of developing a policy/process for follow-up of recommendations, but this was not finalized at the time of the Monitoring Team's visit. Concerning the events surrounding deaths of these eight individuals, two (25%) would be described as sudden death in those with chronic illness. Two (25%) individuals had signs and symptoms for one or more days prior to illness. Of note, six of the eight (75%) had a hospitalization within the prior year. It appeared that those with prior hospitalizations were at higher risk of mortality in the following year. This should be a consideration in the risk rating system that has been developed. For those that have been hospitalized, a system of early intervention (e.g., monitoring, diagnostic testing) might prevent progression into a severe illness. For example, consideration should be given to sending those meeting this criterion who develop abnormal vital signs (e.g., temperature spike, increased respiratory rate) to the ER for diagnostic review at an earlier phase of illness, or have increased monitoring in the residences, or transfer to the Infirmary for more intensive monitoring should this occur. Any change in condition in an individual hospitalized in the prior year might be an important indicator of higher risk of death. Additionally, there were a number of missed opportunities. No extensive record reviews were completed for which summaries were submitted. Based on the Monitoring Team's review of the records of the individuals who died, the following are some of the areas that the Facility should have considered, but did not: ▪ There were two individuals with respiratory concerns as a cause of death. One of these had chronic respiratory failure associated with multiple comorbidities. However, given the number of respiratory concerns and pneumonia cases over time, the need for further respiratory therapy positions should be discussed and determined. As there were only two staff positions for this important clinical service, the Nursing Department assisted when these staff were not available.	

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		The Facility might need to consider a review of respiratory treatments provided by nursing services. Availability of respiratory therapy expertise might need to be expanded to cover all shifts on all days of the week. Alternatively, monitoring the quality of nebulizer and other respiratory treatments by nursing staff might indicate a need for refresher training and nursing assistance to cover other duties which need to occur at the same time. The Facility should monitor this area of health care to ensure there are no delays in providing breathing treatments when needed during off hours when respiratory therapists are not available. These concerns were not reviewed at any of the death reviews, but might assist in creating a corrective action plan. ▪ For an individual with chronic respiratory failure, the record might require an in-depth and historical review to determine whether GERD was treated optimally at an earlier stage in prior years, and whether positioning was in place and monitored once the diagnosis was made. ▪ For one individual with four hospitalizations in six months, only one ISPA from the IDT was developed. This is problematic. That the death reviews did not identify this as a system concern was also problematic. ▪ For one death, it was noted that there were no nursing care plans in place for significant conditions. This indicated that the Nursing Department needed to continue to focus efforts on this aspect of nursing services. The Facility remained out of compliance with this provision. In addition to a lack of follow-up on the external non-facility physician review, the Facility also had not followed up on recommendations related to mortality reviews.	
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.	<u>Medical Department Internal QA System</u> In July/August 2012 and in December 2012, the Medical Department completed internal medical peer review audits. For the July/August and December 2012 internal medical peer reviews, a list of scores for the essential and nonessential components of the general medical audit was submitted per PCP. For the July/August 2012 audit process, there was additional information submitted, but for the December 2012 internal general medical audit, there was no other information submitted. In July/August 2012 and December 2012, the internal medical management audit was also completed, and information for both was submitted. However, the July 2012 data submitted was for a different number of PCPs. It was not clear the reason for the discrepancy in the information for the general audit in July 2012. The dates of the audit were also confusing. The dates of the July summary information (provided in table format) did not agree with the date of the internal medical audit, which was dated 8/1/12. From the forms submitted, it was difficult to determine the date of the audit	Noncompliance

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		versus the date of follow-up by the QA Department. For the internal general medical audit (30 questions) in July 2012, the scores of four PCPs for the essential components ranged from 79 to 100. Compliance for essential components required a score of 100. One PCP had compliance in the essential areas. For the December 2012 internal general medical audit, the scores of the four PCPs for the essential components ranged from 88 to 100. There were two PCPs with scores of 100 percent. For nonessential areas of the general medical audit, in July 2012, the scores of the four PCPs ranged from 93 to 100. Compliance was considered 80 percent. All PCPs were considered compliant. For the nonessential areas of the general medical audit in December 2012, the scores of the four PCPs ranged from 94 to 98. All PCPs were considered compliant. The supporting documentation for the internal general medical audit date for Round#6 in July/August 2012 was submitted. Corrective action plans were identified for three PCPs totaling 14 concerns. Follow-up by QA indicated that there were two that remained outstanding, but the date of this information was not provided. Indicators that needed a corrective action included the following: (2) Is the Active Problem List dated and signed when it was last reviewed? (3) Is there evidence that the Active Problem list was updated with each new problem or as problems were resolved? (4) Is the annual physical exam and summary current? (5) Is the annual physical summary complete, including PMH, family history, and a plan of care? (10) Are the appropriate preventive screening services provided? (14) Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the Quarterly Drug Regimen Review Form? (16) Do the medication orders for acute conditions include indication and duration for all medications prescribed? (18) Are responses to lab values that needed interventions documented in the integrated progress note by the provider? (23) Is the provider's clinical assessment documentation organized in appropriate SOAP format (including assessment and plan)? The supporting data of the internal general medical audit for December 2012 was not submitted. The internal medical management audit data for Round #6 in July/August 2012 was submitted. Two PCPs were reviewed. There were six total action plans generated. An undated follow-up from the QA Department documented that four of these action plans had been completed and two remained outstanding. There was no further information submitted. Indicators that needed corrective action plans included the following: Osteoporosis – (3) Is there a diagnosis of a pathological fracture? Diabetes mellitus - (1)	

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		Is diabetes listed on the active problem list? Pneumonia – (3) Is there evidence that the individual has had a modified barium swallow completed since a diagnosis of aspiration pneumonia? (4) Did the provider order appropriate interventions after the MBS? (5) Did the provider recommend a suction toothbrush for the individual or refer to Dental Clinic? The internal medical management audit data for Round #6 in December 2012 was also submitted. However, it was difficult to interpret, as data from the August review was also included. The data indicated that there were three PCPs reviewed for the internal medical management audit (versus the four noted in the summary information above), and there were a total of eight action plans, which had been followed by QA. Additionally, the chart of "essential and-nonessential compliance" for the internal medical management audits for December 2012, submitted in the Presentation Book, listed five PCPs. There were three that remained outstanding. Indicators of concern included: Urinary Tract Infection - (1) Is Urinary tract infection listed on the Active Problem List? Constipation - (3) Is there evidence that the PCP documented follow up effectiveness of the treatment plan including side effects? Some questions submitted for the December internal medical management audit were derived from the prior audit and were dated in follow-ups of 8/31/12 and 9/8/12, making interpretation difficult. Examples included: Osteoporosis – (3) Is there a diagnosis of a pathological fracture? Diabetes - (1) Is diabetes listed on the Active Problem List? Pneumonia - (3) Is there evidence that the individual has had a modified barium swallow completed since a diagnosis of aspiration pneumonia? (4) Did the provider order appropriate interventions after the MBS? (6) Did the provider recommend a suction toothbrush for the individual or refer to Dental clinic? For these audits, a number of charts with PCPs were provided with no data entered. It was unclear the reason for submitting these additional sheets. There was no differentiation of information from the two audits. There is concern that the action plans of the August audit had not been resolved, but adding them to the findings of the December audit was not helpful. For none of these audits were the clinical indicators listed according to the number of corrective actions generated for each clinical indicator (weak areas), as well as those that needed no corrective actions (strengths). This information would provide the Medical Department some guidance with regard to needs for systems improvements. In summary, the information suggested that QA was completing follow-ups, but the date of the corrective action plan data was not provided for any table, making it difficult to define progress. Combining results of prior audits with current skewed any data that attempted to summarize each audit's results. That supporting information for an	

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		internal general medical peer review was not provided was problematic. Further, that the numbers of PCPs listed did not agree in all documents appeared to challenge the reliability of the information. There was no inter-rater reliability information shared between the QA Department and the internal medical peer review by the Medical Department. There was no analysis of review of inter-rater reliability between the December internal peer review and the external medical peer review, either in the general medical audit or the medical management audit. The QA representative did not provide evidence of tracking corrective action plans to completion, did not provide the timeline of QA monitoring for the corrective action plans, did not provide a list of indicators which identified strengths and weaknesses, and did not provide a quarterly report to the Medical Department and the Facility reviewing monitoring findings. It is recommended that the Medical Department administration become familiar with these various audit processes and role of QA, and that QA provide the needed audit assistance, tracking, and inter-rater reliability data needed. <u>Medical Department Initiatives Based on External and Internal Medical Peer Review Findings</u> For the internal medical peer review findings, there was no evidence submitted to show that the Medical Department completed medical staff meetings to discuss results. There was no evidence submitted that the minutes of medical staff meetings documented identification of areas needing improvement. There was no evidence that minutes of the medical staff meetings documented development of a plan of improvement. There was no evidence that minutes of the medical staff meeting documented implementation of a systemic plan of correction for the Facility. <u>Medical Department Internal Reviews/ Initiatives and Improvement Projects</u> The Medical Department implemented an additional process for internal reviews. Specifically, quality indicators were identified for six clinical areas. Topics included: Constipation, seizures, ER/hospital visits, diabetes mellitus, osteoporosis, and hypertension. The information provided by the Facility indicated the auditing process for these tools began in November 2012. The Medical Compliance Nurse was to complete the audits. However, that position had been vacant for several months and filled as of March 2013. Numerous examples of raw data were submitted, completed by a member of the Nursing Department for November 2012 through January 2013, for the topics listed above and additional topics of metabolic syndrome, and Down syndrome. This information is discussed in further detail with regard to Section H.4. There was no analysis of the information or evidence the information had been discussed with the medical staff or steps taken to create an improvement plan based on this raw data.	

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L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the Monitoring Team's last visit, no additional Medical Department policies/procedures/protocols were created. The Medical Department's action plan included the development of a post ER Visit/Hospitalization Policy that would provide guidance concerning actions and time frames to be followed upon return. However, as of the Monitoring Team's visit, this had not been started. There were no new clinical guidelines developed and implemented since the Monitoring Team's last visit. Compliance for this subsection will require a set of policies and procedures that guides each aspect of medical services provided by the Medical Department. These policies should be included in the Facility's policy review system. Each policy should be reviewed, and if necessary, updated once every 365 days. Examples of categories for which policies and procedures would be expected for guidance include the following: ▪ Staffing and administration - caseloads, categories of topics for CME, CPR certification, etc.; ▪ Organizational procedure and role of the integrated clinical services meeting; ▪ Routine care and documentation standards; ▪ Updating diagnoses using ICD and DSM nomenclature; ▪ Preventive care; ▪ Acute care; ▪ Utilization of clinical guidelines and national standards as part of practice pattern; ▪ Tracking missed appointments; ▪ External peer review; ▪ Internal peer review and inter-rater reliability; ▪ Role of QA/QI Department in monitoring/guiding the Medical Department; ▪ Internal QI monitoring initiatives; ▪ Mortality review recommendations; • Role of ethics committees; and • Others as indicated. This is not meant to be an exhaustive list, but is intended as guidance. Updating any current Medical Department policies, and determining policy gaps is often the initial step. The Facility remained out of compliance with this provision.	Noncompliance

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

1. CME activities should focus on topics important to care of the IDD population (i.e., primary care of diseases common to the IDD population). Documentation of coursework should demonstrate the subject material covered. (Section L.1)
2. The Integrated Clinical Services Committee meeting minutes should include a brief summary of the ISPA's response to the concern to ensure the content of the ISPA is communicated to all members of the committee, especially those not in attendance at that time. (Section L.1)

3. With regard to the Integrated Clinical Services meetings:
    a. The Committee should focus its efforts on engaging in critical clinical discussion to ensure adequate treatment as well as preventative strategies.
    b. The 24-hour log should be made more user-friendly by reversing the chronological order, and/or placing those concerns to be discussed that morning in a separate listing.
    c. Assignment should be made of record reviews for acute care admissions to the hospital (and specific types of ER visits) with clear due dates.
    d. The committee should review more thoroughly the contents of ISPAs at the morning meetings, as well as important consults with brief documentation in the minutes.
    e. A typed copy of the Hospital Liaison Nurse report in the minutes would provide clarity to this document. (Section L.1)
4. A systems approach should be used to improve the lack of information often found in the family history section of the annual medical assessment. (Section L.1)
5. The Medical Department should develop and implement a tracking system of missed/no show appointments, including the type/specialty of appointment missed, the reason missed, the follow-up reschedule date, whether the rescheduled appointment was completed, and the number of days from the first appointment missed to the completed appointment. If there are serial missed appointments by an individual, there should be evidence of referral to the IDT and ISPA that addresses the concern. (Section L.1)
6. If an individual has received the Hepatitis B vaccination in the past, the dates of vaccination, along with the immune status (if subsequently measured) should be maintained in the record on the preventive care flow sheet and carried forward to the next preventive care flow sheet. Alternatively, this may be also documented in the annual medical assessment. (Section L.1)
7. The Facility should follow CDC and local county health department guidelines in determining vaccination schedules (e.g., Tdap, pneumovax, PCV13, etc.) for eligible individuals residing at CCSSLC. It is recommended that a policy for updating the vaccination schedule be developed and implemented, reflecting the CDC guidelines. (Section L.1)
8. An addendum to the osteoporosis policy should include guidance concerning testing for secondary causes of osteopenia/osteoporosis. (Section L.1)
9. For the dietary assessments/consultations, the dietary department should update the diagnoses in the nutritional evaluations, and provide precise calculations of calcium and Vitamin D average intake per day in the diet, indicating when additional supplements should be prescribed. (Section L.1)
10. A review of bowel movement records and bowel management should be completed for individuals that are sent to the ER or hospitalized for small bowel obstruction. This would include a review of early warning signs of abdominal pain or discomfort or constipation, including subtle gestures or sounds that indicate to staff that a concern needs to be addressed. The Pharmacy should conduct a review for these individuals of medication that contributes to constipation. (Section L.1)
11. For individuals with pressure sore on the buttocks, and/or coccyx, reviews should be completed of the preventive plans and monitoring of plans to ensure they are being carried out correctly. Ulcers in these areas of the body should generate a care plan that reflects many aspects of health care, including frequent repositioning, daily observation of skin integrity, nutritional status, and a review of the type and condition of the chairs and wheelchair used by these individuals. Maintenance schedules might need to be reviewed. A review to determine the need to revise the seating/cushions/molded parts to protect and enhance the posture of the individuals might be indicated. (Section L.1)
12. The Facility should develop a tracking system for seizures that is consistent across campus, that provides updated information in the active medical record rapidly, and ensures the neurology consultants receive complete and timely information. (Section L.1)
13. The Medical Department should ensure timely communication with the neurology consultants for changes in neurological conditions or changes in seizure activity and this communication should be reflected in the active record. (Section L.1)
14. A seizure committee should be created to provide oversight and tracking of seizure management, including reviewing training, accuracy of documentation of seizures, and seizure log completion. (Section L.1)

15. The Medical Director should further review the number of hours available for neurology consultation to determine if more hours, and/or further on-site clinics or off-site consultations are needed. (Section L.1)
16. For each of the individuals with a DNR status, a clear summary of current data should be available as evidence to justify the severity of the condition warranting DNR consideration. Only individuals who meet the criteria in State Office policy and related statutes/regulations should have DNR Orders in place at the Facility. The Facility ethics committee minutes should be part of the summary available in the record to justify DNR status, if the ethics committee met to discuss that individual. (Section L.1)
17. The Medical Department should formalize follow-up of peer review findings, including minutes of meetings at which the results, trends, and system improvements that should be considered are discussed. (Section L.2)
18. The QA Department should be provided guidance regarding that department's role in follow-up and documentation of follow-up of corrective action plans to completion. (Section L.2)
19. The minutes of the administrative death review should include discussion of clinical death review recommendations that do not become administrative death review recommendations, including the reason(s) they were not adopted. (Section L.2)
20. The Facility should develop and implement a process for follow-up of recommendations from the Clinical Death Reviews and Administrative Death Reviews, and a monitoring system should be implemented to ensure there is closure to these recommendations. (Section L.2)
21. The Facility should review the need for additional respiratory therapy services to cover all shifts and all days of each week. (Section L.2)
22. The Medical Department/QA Department should prioritize the clinical indicators by reviewing those indicators with the lowest scores and developing an improvement plan/corrective action plan. (Section L.3)
23. The Medical Department should review the current departmental policies and procedures. Updating these policies and creating policies to provide guidance in all areas of medical services is needed. (Section L.4)
24. A system is needed to provide routine updating of Medical Department policies and procedures on a yearly basis, or more frequently as needed. (Section L.4)

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 Self-Assessment; o CCSSLC At-Risk Individuals list; o CCSSLC's Nursing Department Presentation Book; o CCSSLC's Section I Presentation Book; o CCSSLC's Infection Control Presentation Book; o CCSSLC's Monitoring Tools for Nursing and raw data; o CCSSLC's minimum staffing numbers for nursing; o CCSSLC's Infection Control Monitoring Tool data; o CCSSLC's Corrective Action Plans for Section M; o CCSSLC's lists of individuals who were seen in the Infirmary, emergency room, and hospital; o Infection Control Summary Reports; o Medication Variances Monthly Summary data report; o SSLC Nursing Quality Assurance Audit Process, dated 3/21/13; o Hospital Prevention Health Monitoring Tool and raw data; o Daily Check of Emergency Cart data; o CCSSLC Medication Reconciliation Procedure; o Unexplained Medication Excess/Shortages data; o Customer Medication Fill Procedure (Draft); o Medication Variance Forms Feedback report; o Medication Administration Observation form, revised 3/8/13; o Emergency Competency Checklist data; o Nursing Protocol Analysis Procedure; o Emergency Equipment Checklists data; o Medical records for the following individuals: Individual #127, Individual #182, Individual #155, Individual #326, Individual #321, Individual #340, Individual #245, Individual #305, Individual #357, Individual #167, Individual #156, Individual #210, Individual #338, Individual #326, Individual #161, Individual #89, Individual #234, Individual #153, Individual #282, Individual #263, Individual #223, Individual #235, Individual #209, Individual #87, Individual #310, Individual #335, Individual #355, Individual #10, Individual #4, Individual #65, Individual #353, Individual #156, Individual #357, Individual #270, Individual #314, Individual #292, Individual #189, Individual #244, Individual #213, Individual #341, Individual #71, Individual #62, Individual #208, Individual #63, Individual #140, Individual #231, Individual #69, Individual #9, Individual #333, Individual #214, Individual #198, Individual #182, Individual #224, Individual #74, Individual #165, Individual #142, Individual #153, Individual #91, Individual #313, Individual #7, Individual #270, Individual #128, Individual #296, Individual #321, Individual #97, Individual #255, Individual #297, Individual #191, and Individual #117;

	○ Nursing Protocol Audit form; ○ Mortality Action Plans; ○ QI Safety Committee Meeting minutes, dated 8/28/12, and 11/27/12; ○ 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); ○ Real Time Audit tool data for Infection Control; ○ CCSSLC Outbreak timelines; ○ Infection Control Committee meeting minutes, dated 8/9/12, 12/4/12, and 3/25/13; ○ CCSSLC's monthly Infection Control summary report list; ○ CCSSLC Immunization List; ○ Drug Utilization Discrepancy Reports; ○ Drug Utilization Reports - Antibiotics; ○ Weekly Infection Control Reports; ○ Pneumonia Tracking Reports; ○ Infection Control Environment Checklists: ○ Hospitalization Prevention Committee Meeting minutes, dated 8/20/12, 9/10/12, and 9/27/12; ○ Medication Administration Observations raw data; ○ Nurse Educator Medication Observation and Emergency Equipment Observation forms for onsite medication observations; ○ Medication Variance data; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 7/9/12, 12/5/12, and 1/30/13; ○ Medication Committee meeting minutes, dated 11/29/12, 1/3/13, 1/22/13, 3/28/13, and 4/3/13; ○ Medication Administration Observation Trend data; ○ Protocol for Medication Cart Exchange; ○ CCSSLC Initiatives/Activities Update since Last Compliance Round Report; and ○ CCSSLC Emergency Medical Drills data. ▪ **Interviews with**: ○ Colleen M. Gonzales, BSHS, Chief Nurse Executive; ○ Peggy Sue Miclan, RN, Program Compliance Nurse; ○ Della Cross, RN, Nurse Educator; ○ Kristen Middleton, RN, Nurse Educator; ○ Pamela Nichols, RN, Infection Control/Employee Health Nurse; ○ Michelle Warren-Pile, RN, BSN, Assistant Infection Control Nurse; ○ Patty Glass, RN, Nurse Case Manager Supervisor; ○ Lindsay Hertz, RN, Psychiatric Nurse; ○ Michelle Lord-Arteaga, RN, Psychiatric Nurse; ○ Mary Hernandez, Competency Training Department, Trainer;

	○ Beverly Okin-Larkin, Systems Analyst; ○ Karney Campos, Training Assistant; ○ Melinda Eldrige, Competency Training Department, Director; ○ Angela Roberts, Au.D., Director of Habilitation Therapies; and ○ Leslie Hernandez, RRT, Respiratory Department. ▪ **Observations of**: ○ Medication Administration in the Infirmary and Ribbon Fish 3; and ○ Use of emergency equipment at Ribbon Fish 4.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section M. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section M, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Since the last review, the Health Monitoring Tools for Nursing had been revised and consolidated into six tools. The Monitoring Team's review of the revised Monitoring Tools found problematic issues that could compromise the reliability of the data generated and would result in inadequate measurement of the quality of the nursing documentation. (Specific details are provided with regard to Section M.1.) At the time of the review, the Facility had implemented the revised nursing monitoring tools. However, based on a review of the Facility's Self-Assessment: ○ It was unclear why only some of the initial findings generated from each tool implemented were reflected in the Facility's Self-Assessment. Much of the data, addressing the quality of the nursing documentation was not included, as well as what the specific criteria for compliance constituted for the different areas audited. ○ In some of the sub-sections for Section M, some of the items presented did not reflect the requirements of the specific provision or the quality of the documentation for each area upon which the Monitoring Team's findings focused. As the Facility reviews its monitoring tools, the Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ○ In addition, there was no inter-rater reliability reported for any of the monitoring tools. Based on the problematic issues the Monitoring Team found regarding the current monitoring tools' instructions noted with regard to Section M.1 that could affect the consistency in monitoring and the validity of the results, it was likely that different auditors would score compliance differently. ▪ Although there was a significant improvement in the presentation of the data that was contained in the Facility's Self-Assessment for Section M, the Facility did not have a plan for consistently presenting the data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ○ Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria had been used to determine adequate documentation without citing a standard, such as a nursing protocol, as the criteria for compliance. In addition, at times, indicators combined more than one item, so

	that if data were presented, it would have been impossible to determine which of these requirements had been met and which had not. o Did not address the quality as well as the completion of documentation. o There was improvement noted regarding the identification of the sample sizes used for some of the monitoring including the description of the overall population from which the sample was selected (N) and a percent sample size. o The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. ▪ The Facility rated itself as being in compliance with sub-section M.4 of Section M. However, there was no supporting data contained in the Self-Assessment to substantiate the rating in alignment with the requirements of the Settlement Agreement. In addition, the findings of the Monitoring Team were not consistent with the Facility's findings. ▪ The Facility's data identified some of the areas that were in need of improvement and provided some promising initial attempts at analyzing the information, identifying some potential causes for the issues, and possible barriers to improvement. However, more work needed to be done regarding the analysis of the data and connecting any monitoring findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Since the last review, CCSSLC's Nursing Department experienced an increase in staff turnover as well as in some key leadership roles which included: ▪ In March 2013, a full-time Assistant Infection Control Nurse (RN) was hired; ▪ In February 2013, the Nurse Operations Officer (NOO) position became vacant; and ▪ In May 2013, the current CNE will move into the NOO position and a newly-hired Registered Nurse will fill the CNE position. Since the last review, the Nursing Department had had significant staffing challenges. The fill rate had dropped to 83% in December 2012 for RNs and 78% for LVNs. At the time of the review, the total nursing position fill rate had improved to 97% for the RN positions, and remained at 78% for the LVN positions. This included a total of 112.7 allotted positions, including 61.2 for Registered Nurses and 51.5 for Licensed Vocational Nurses. The CNE reported that due to the staffing issues, some of the monitoring activities had not been consistently conducted, and the staffing issues were a significant factor in the lack of overall progress regarding the requirements of the Settlement Agreement for Section M. Some of the Facility's positive steps forward included: ▪ The reliability of the Infection Control data continued to improve as reflected from data generated by comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics. ▪ The Facility continued to generate data from the Real Time Audit for Acute Infections, and had begun to review the data by item, by individual, and by home. ▪ Since Risk Management, Respiratory Therapy, and the Nurse Educators had been

	completing monthly spot checks, there had been a significant decrease in blanks found on the emergency cart checklists. ▪ The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at Ribbon Fish 4 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear that the consistent drills and spot checks regarding the emergency equipment were having very positive outcomes. ▪ The Facility had implemented procedures to accurately track the medications being brought to the buildings in an attempt to reconcile the number of excess medications that were being returned to the Pharmacy without explanation. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, the actual implementation of nursing protocols, and the problematic issues regarding the under-reporting of medication variances and excessive unexplained medications being returned to the Pharmacy were very concerning at this juncture in the review process.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections 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, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency systems. 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 and recommendations addressing nursing documentation regarding restraints is included above with regard to Section C. In assessing its progress, CCSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ The Facility reported that since the last review, there had been a decrease in Registered Nurses and Licensed Vocational Nurses fill rates from 97% of RN positions and 80% of LVN positions in May 2012 to 83% for RNs and 78% for LVNs in January 2013. The Facility's Self-Assessment indicated that efforts regarding recruitment and retention continued to present challenges. However, there was no indication from the Self-Assessment regarding how the staffing challenges were being addressed or how they had affected any care and services for the individuals. These fluctuations are discussed further below with regard	Noncompliance

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		to staffing. ▪ Although the presentation of data found in the Self-Assessment under Section M.1 was significantly clearer than noted in past reviews, the procedure that was described in the Presentation Book for Section M regarding how the auditing was conducted appeared to have generated unreliable findings especially regarding nursing documentation and nursing protocols. The procedure for nursing protocol auditing and analysis indicated that nurses were required to submit copies of the Integrated Progress Note (IPN) that demonstrated the nursing protocols were used. However, reviewing one IPN does not usually capture the entire clinical picture of care provided to an individual from the identification of a change in status to the resolution or need for ongoing assessments in alignment with nursing protocols. Consequently, the Facility's conclusion reported in the Self-Assessment indicating that there was an increase in compliance in areas addressing nursing assessments and documentation due to the implementation of the Nursing Protocol audit did not comport with the findings of the Monitoring Team. Although there were more entries found in the IPNs from nursing than during previous reviews, there were not ongoing adequate nursing assessments found in the documentation in alignment with the nursing protocols for the particular health issue the individuals were experiencing. Consequently, the additional documentation that was found did not result in an improvement in clinical care. <u>Self Rating</u> The Facility's Self-Assessment indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance. While some upward trends are evident, continued mentoring and monitoring nurses to ensure the consistent performance of Best Practices is needed." Since the last review, the State had modified the Nursing Health Monitoring Tools, including reducing the number of tools to six. These included: ▪ Annual Nursing Assessment Monitoring Tool; ▪ Care Plan Monitoring Tool; ▪ Nursing Infection Control Monitoring Tool; ▪ Nursing Pain Management Monitoring Tool; ▪ Skin Integrity Monitoring Tool; and ▪ Urgent Care/ER/Hospitalizations Monitoring Tool. A review of these Monitoring Tools by the Monitoring Team found there were some significant problematic issues that would affect the reliability of the data generated such as: ▪ The instructions contained on the tools addressing the nursing documentation	

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		did not indicate how the quality of the documentation was to be determined, such as using the nursing protocols as the standard for compliance rather than depending on auditor judgment; ▪ A number of items on the tools contained several elements within a given item making it difficult to identify which elements were in compliance and which were not. For example, one item contained on the Urgent Care/ER/ Hospitalizations Monitoring Tool included elements regarding a full set of vital signs, the chief complaint/presenting problem, a systems review including a skin assessment as appropriate, legibility, and accuracy. This one indicator was to be audited and scored either yes or no. However, in the event the item was found not to be in compliance, it would be difficult if not impossible to determine which of the above elements were found to be in or out of compliance, making it difficult to track trends and focus corrective actions plans on the problematic elements; and ▪ There was no mention in the items or the instructions on the Nursing Care Plan Monitoring Tool that the interventions found in the care plans should be in alignment with the assessments contained in the nursing protocols for specific health issues. Overall, the problematic issues found in relation to the current Health Monitoring Tools did not lend to generating an adequate and accurate review of the clinical care and treatment an individual received. As noted above, the Facility's presentation of the data contained in the Self-Assessment for Section M was significantly clearer regarding the organization and format. In addition, there were promising initial attempts at providing some analysis of some of the problematic areas the Facility found in its data. With the Facility's efforts at presenting some of the data in a more meaningful structure, it was evident from interviews with the CNE that the process of interpretation and analysis of these data was becoming clearer to the Department. It is the Monitoring Team's hope that the ongoing analysis of data should then result in the development and implementation of plans of action addressing the areas that reflected problematic trends. As noted in previous reports, it was clear to the Monitoring Team that the Facility was continuing to invest a great deal of energy in collecting monitoring data, organizing it in a meaningful way, and taking steps to interpret the findings. The Facility should continue to consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and then provide training to the disciplines regarding how to analyze their data to identify problematic trends. <u>Staffing</u> At the time of the review, CCSSLC had a census of 246 individuals. Since the last review,	

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		CCSSLC had some changes regarding the Nursing Department and nursing positions, which included: ▪ In March 2013, a full-time Assistant Infection Control Nurse (RN) was hired; ▪ In February 2013, the Nurse Operations Officer (NOO) position became vacant; and ▪ In May 2013, the current CNE was scheduled to move into the NOO position and a newly-hired Registered Nurse would fill the CNE position. In addition, at the time of the review, the Nursing Department had a total of 112.7 allotted positions, including 61.2 for RNs and 51.5 for Licensed Vocational Nurses. At the time of the review, the total nursing position fill rate was 97% for the RN positions, and 78% for the LVN positions. From a review of the Facility's nursing staffing data and discussions with the CNE, since the last review the Nursing Department had had significant staffing challenges where the fill rate had dropped to 83% in December 2012 for RNs and 78% for LVNs. Although the fill rate had increased to the current level of 97%, the LVN vacancies had continued to be problematic to fill. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as previously recommended, as CCSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. <u>Quality Enhancement Efforts</u> Since the last review, the Quality Assurance Nurse, the CNE, and the Program Compliance Monitors had met in February 2013 to prioritize which of the new state Nursing Monitoring Tools to initiate. At the time of the review, the QA Nurse and the PCM were using the Annual Nursing Assessment Monitoring Tool, the Care Plan Monitoring Tool, and the Urgent Care/ER/Hospitalizations Monitoring Tool, and were in the process of establishing inter-rater reliability. In addition, the PCM had initiated audits using the Facility's Nursing Protocol audit. As noted above, the procedure of reviewing one IPN in determining compliance in providing appropriate nursing care did not generate overall reliable findings and did not result in findings that comported with the Monitoring Team's findings noted below addressing the nursing assessments and documentation of individuals with acute changes in status. In addition, the Facility reported that a Hospital Prevention Health Monitoring Tool was developed in 8/2012 to assist in identifying issues that might have prevented an individual's hospitalization. The PCM completed the audit for at least three individuals who required hospitalization. The Hospitalization Prevention Committee, which had been established in August 2012, initially discussed the findings. Although the minutes of the committee meetings included some very promising findings and action plans	

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		addressing problematic issues, most of the completion dates were left blank and thus, it could not be determined if recommendations for system changes were actually implemented. In addition, the committee was dissolved in November 2012, and the findings of the Hospital Prevention Health Monitoring Tool were to be discussed during the individual's ISPA meeting. However, the documentation contained in the Presentation Book for Section M.1 indicated that the Facility needed to continue to work with teams in incorporating this information into the ISPAs. No information was provided regarding how this process was being addressed or what positive outcomes, if any had been achieved. Consequently, it was unclear to the Monitoring Team if this promising process was still in place at the time of the review. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ The Facility reported that it had implemented five additional nursing protocols, including those for: Emergency/Hospital Transfers, Fall or Suspected Fall, Pain, Hypoglycemia (low blood sugar), and Suspected Fracture/Dislocation. The additional nursing protocols to assist in the development of clinically adequate care plans to guide nursing practices were a positive step forward. However, at the time of the review, little to no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and/or identify the parameters and time frames for reporting symptoms to the practitioner/physician and PNMT, if indicated. A review of 11 individuals' Infirmary IPNs (i.e., Individual #127, Individual #182, Individual #155, Individual #326, Individual #321, Individual #340, Individual #245, Individual #305, Individual #357, Individual #167, and Individual #156) who had been transferred to a community hospital, emergency room, and had been in the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%) in alignment with the nursing protocols. ▪ The documentation indicted that the licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. Due to the lack of ongoing clinically appropriate nursing assessments, changes in status were only identified when	

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		the individual was already acutely ill. ▪ The documentation indicated that appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate ongoing assessments as dictated by the symptoms in none (0%) of the cases in alignment with nursing protocols. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in none (0%) of the cases in alignment with the individuals' overall medical status. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases in alignment with the nursing protocols addressing the specific health issue. ▪ The documentation indicated that all acute illness/injuries were followed through to resolution in none (0%) of the cases. A review of these 11 individuals found basically the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past five reviews. The overall problematic issues that were found in all 11 records included: ▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status, and warranted nursing assessments; ▪ Although since the last review, an increase in nursing documentation was found in the IPNs, the documentation did not address the emerging clinical issues. This was due to the lack of a structured system driving the type of nursing assessments that should have been conducted for the health issues and the associated documentation of those assessments. This structure was available through the nursing protocols, but nurses were not using the protocols to drive their assessments and/or documentation. ▪ Due to the lack of consistent nursing assessments found in the documentation, it was largely impossible to accurately determine when changes in status were initially occurring; ▪ There continued to be a lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There continued to be inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (as needed medications); ▪ There continued to be a lack of assessment and/or inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The IPNs continued to lack specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There continued to be a lack of documentation of individuals' activities and	

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		tolerance for activities during the day, evening, and night to indicate any associated changes in mental status from physical changes in status; ▪ There continued to be a lack of documentation indicating that lung sounds were regularly assessed and documented for individuals with significant respiratory issues; ▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation issues or receiving PRN laxatives; ▪ Physicians/Practitioners were not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was little documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ There was a lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ There were missing weights, and intake and output values for individuals with significant fluid and weight issues; ▪ There was a lack of communication noted between shifts regarding status changes, and the need for regular nursing assessments and follow-up; ▪ There was inadequate documentation noted regarding the individual's status and assessment at the time of transfer to the hospital or Infirmary, or emergency room; ▪ In the IPNs, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ There was a lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ When nursing protocols were used to guide nursing assessments, they were found to be initiated only after the individual was ill and not as proactive measures to prevent the occurrence of acute health issues; ▪ Nursing Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations or in alignment with nursing protocols; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. Although there were some IPNs that contained an adequate nursing assessment, the lack of consistency of these notes rendered the overall care of the individuals insufficient to	

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		address their specific needs. Although the Facility reported that the nursing protocols had been implemented, there was no indication they were being used consistently to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices. In addition, mentoring and supervision of nurses should focus on the consistent use of the nursing protocols. As noted in previous reports, due to the number of individuals with complex medical needs at CCSSLC, this area should be considered a priority for Facility review, and the development and implementation of specific action plans addressing the continuing problematic issues that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that very few documents were missing from the active records. The information contained in the Facility's Self-Assessment for Section M.1 indicated that from a review of 100% of the records, there was variability in compliance scores regarding male and female breast exams, menses, vital signs, and weights. However, it was unclear if the data reflected that the documents addressing these issues were missing or if the documentation for these issues was not completed. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control (IC)</u> At the time of the review, the Facility recently had hired a full-time RN in the position of the Assistant Infection Control Nurse. From the Facility's Self-Assessment, a review of the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse, review of the documentation, and information gathered during the review, some positive steps forward had been made regarding the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ The Facility again created an exceptional separate Presentation Book addressing Infection Control. It clearly presented a significant amount of information regarding the activities of the IC Nurses since the last review. ▪ The Facility continued to refine the process addressing data reliability, to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by comparing the Infection Control Reports,	

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		Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following represent the compliance percentages of antibiotics included in all reports: 97%, 94%, 91%, 96%, 88%, and 93% from September 2012 through February 2013, respectively. These data reflected a very positive and overall consistent increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports the residential staff completed. ▪ Since the last review, the Facility had completed a written procedure that outlined CCSSLC's process to ensure the IC data was reliable. ▪ At the time of the review, 100% of the individuals' immunization data had been entered into the Avatar database and the documentation placed in the Active Records. ▪ The Facility continued to generate data from the Real Time Audit for Acute Infections. The documentation contained in the Presentation Book indicated that since the last review, the Facility had begun to review the data by item, by individual, and by home, which was a very positive step forward. Although the number of audits conducted for the quarter was included in the IC Committee Meeting minutes, no analysis of the findings was found in the minutes. These data, along with other monitoring data addressing IC issues, and data regarding actual infection rates should be aggregated and analyzed in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. ▪ The documentation the Facility provided regarding outbreaks of Influenza A, Influenza B, and Scabies that occurred since the last review indicated that the IC Nurses provided a number of appropriate and timely in-service training sessions to staff in response to the outbreaks. ▪ The content of the minutes of the Infection Control Committee meetings continued to improve regarding the information and issues discussed addressing some of the data generated from the IC Monitoring Tools. Although the IC Nurses made positive steps forward, there continued to be a number of significant problematic areas regarding infection control that were in need of further attention, including; ▪ Although the Facility had developed and implemented an immunization database, consistent with past reviews, the Facility could not generate a list of all the individuals whose past immunizations had been researched, and were updated, as appropriate. As noted from previous reports, a formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines.	

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		▪ Regarding Infection Control Environmental Checklists, as was noted in the past report, there was no indication that the problematic issues identified on the tools had been adequately addressed. In addition, the results of these audits were not trended or analyzed in conjunction with other IC data to determine if there was a correlation between the problematic environmental issues and rates of infections. ▪ Consistent with the same problematic issues that were found during the previous reviews regarding nursing care plans, a review of 33 episodes of contagious infectious illnesses including MRSA, Scabies, C diff, and Influenza A and B, for 27 individuals (i.e., Individual #210, Individual #338, Individual #326, Individual #161, Individual #89, Individual #234, Individual #153, Individual #282, Individual #263, Individual #223, Individual #235, Individual #209, Individual #87, Individual #310, Individual #335, Individual #355, Individual #10, Individual #4, Individual #65, Individual #353, Individual #156, Individual #357, Individual #270, Individual #314, Individual #292, Individual #189, and Individual #244): found that of the 33 episodes, 17 (52%) were found to have had an acute care plan addressing the infectious issue. The individuals who did not have a care plan addressing the infectious issue were Individual #338, Individual #326, Individual #161, Individual #234, Individual #153, Individual #282, Individual #223 (two care plans missing), Individual #65, Individual #353, Individual #156, Individual #357, Individual #292, Individual #189, Individual #244, and Individual #335. In addition, of the 17 Nursing Care Plan reviewed, none were found to be clinically adequate (0%). This is discussed in more detail with regard to Section M.3. The Facility should develop and implement a system to ensure the care plans for individuals with infectious/communicable disease are clinically appropriate and consistently implemented. ▪ A review of the Infection Control Committee meeting minutes found that while there was some improvement made regarding analyzing some of the Facility's IC data, there were still a number of other monitoring data findings that were not being reviewed and analyzed to comprehensively assess the Facility's infection control practices. The Facility should conduct analyses of all the IC monitoring data, implement plans of action addressing problematic issues, document the interventions implemented, and the resulting outcomes. Although the Facility had made some positive steps forward, there continued to be a significant amount of work yet to be done regarding Infection Control in order to make substantial gains in meeting the requirements of the Settlement Agreement. As noted in previous reports, consideration should be given to having additional expertise in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control Systems in alignment with IC standards of practice and the Settlement	

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		Agreement, as well as providing professional feedback regarding the quality and completeness of the Infection Control Program. <u>Mock Code Drills and Emergency Response Systems</u> CCSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps were initiated regarding this area: ▪ The Facility's review of the monthly Emergency Cart Checklists from May 2012 through February 2013 indicated that there was an increase in compliance regarding the daily Emergency Cart checks ensuring that the equipment was available for all emergency situations. In addition, the Facility indicated that the spot checks conducted by Respiratory Therapy and the Nurse Educators had assisted in maintaining compliance. ▪ The Facility's review of the monthly Emergency Competency skills checklist from May 2012 through January 2013 indicated that there was variability in the compliance scores regarding the nurses passing the skills checklist. However, overall, the data demonstrated improvement in this area. In addition, other positive steps made since the past review included: ▪ The Nursing Educators continued conducting spot checks addressing emergency equipment use and oxygen flow rates. The Monitoring Team's observations of nurses demonstrating the emergency equipment at Ribbon Fish 4 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear to the Monitoring Team that the consistent drills and spot checks regarding the emergency equipment were having a positive impact in this area. ▪ Since the last review, the Facility had expanded its emergency drills to include a variety of emergency scenarios. Although the Facility implemented positive steps addressing the Emergency Response System, there were problematic issues found that should be addressed in order for additional progress to be made: ▪ There was no clinical review of the Mock Code Drills or the actual medical emergencies that occurred at the Facility. Consequently, the status of the Facility's emergency systems was not being reviewed, discussed, or tracked by any clinical staff. The Facility in conjunction with the State Office should clarify the role of the clinical staff regarding the review of Emergency Mock Code Drill data and data addressing the actual medical emergencies. ▪ There was no analysis or associated plan of correction found regarding the data addressing Emergency Mock Drills, especially since there was some low pass percentages of the drills conducted from September 2012 through January 2013 as noted below.	

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		The data from the drills conducted since the last review were as follows: ▪ 19 drills conducted in September 2012 – 13 passed (68%); ▪ 20 drills conducted in October 2012 – ten passed (50%); ▪ 19 drills conducted in November 2012 – 18 passed (95%); ▪ 18 drills conducted in December 2012 – 11 passed (61%); and ▪ 17 drills conducted in May 2012 – 12 passed (71%). The Facility had made some positive steps forward regarding CCSSLC's Emergency Response System. However, there continued to be some problematic issues as noted above. The Facility reported that: "based on the findings from this self-assessment, this provision is not in substantial compliance. While some upward trends are evident, continued mentoring and monitoring nurses to ensure the consistent performance of Best Practices is needed." Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. CCSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps had been taken regarding this requirement of the Settlement Agreement: ▪ The Facility indicated that a review of Quarterly and Annual Nursing assessments from 5/1/12 through 1/31/13 conducted to determine if they had been completed and filed in the Active Record within the month they were due found the assessments were consistently available on the computer (96%-100% compliance). However, they were not consistently found in the Active Records (64%-88% compliance). The Facility's Self-Assessment indicated that the low compliance scores were attributed to the implementation of the new Risk process for two pilot teams, mandatory training requirements, and the resulting increased workload. In response to these data, the Facility reassigned the filing responsibilities on the Comprehensive Nursing Assessments from the nurses to the Medical File Clerks. On a positive note, at the time of the review, the Monitoring Team found that of 22 individuals' Comprehensive Nursing Assessments reviewed, all were found in the active record. This indicated the interventions the Facility implemented in response to the low compliance scores resulted in a positive outcome. In addition, the Monitoring Team found that 95% of the Comprehensive Nursing Assessments reviewed were timely completed in alignment with the Facility's data as noted below. <u>Self-rating</u>: The Facility's Self-Assessment indicated that: "Based on the findings of the self-	Noncompliance

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		assessment, this provision is not in substantial compliance because assessments are not consistently filed in the active record within the month due." The Facility's finding of noncompliance was consistent with the Monitoring Team's findings. However, the reasons for the Monitoring Team's finding of noncompliance as noted below, were based on specific findings related to the significant problems with the quality of the content of the Comprehensive Nursing Assessments. This was not included in the Facility's Self-Assessment data. As noted above and previously with regard to Section M.1, challenging staffing issues, since the last review, some turnover in key Nursing leadership positions, and the training and implementation of the new At-Risk process had contributed to the lack of overall progress for the Nursing Department in some areas. However, of major concern for the Monitoring Team was that thus far in the review process, CCSSLC had not yet developed clinically appropriate curricula addressing the quality of the documentation contained in the Comprehensive Nursing Assessments. A number of examples of Comprehensive Nursing Assessments were provided in the Presentation Book for Section M.2 to demonstrate to the Monitoring Team that the nursing assessments contained an adequate clinical analysis of the individual's progress. However, due to the lack of implementation of the nursing protocols resulting in the lack of relevant nursing assessments being conducted on individuals, there was a significant lack of clinical data generated during the quarter to even analyze. Consequently, the Monitoring Team found these Comprehensive Nursing Assessments to be clinically inadequate. They reflected that nursing staff lacked competency with this requirement of the Settlement Agreement. Unfortunately, most of the Monitoring Team's findings below revealed a lack of competency in this area. The Quarterly/Annual Nursing Assessments for 22 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including those for: Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues. ▪ Of the 22 individuals' nursing quarterly assessments reviewed, 21 (95%) were timely completed. Assessments not timely completed included those for: Individual #296 that was found to be incomplete. ▪ There was an adequate analysis of the health/mental health data between the	

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		previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. ▪ There was an adequate assessment of the high and medium risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. The Monitoring Team found that essentially no progress had been made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving, maintaining, or getting worse. The consistent lack of progress found regarding the quality of the Comprehensive Nursing Assessments was concerning due to the potential impact it had on the health and wellbeing of individuals the Facility supported. In addition, the Facility's action plan addressing this requirement did not include any specific action steps regarding improving the quality of the nursing assessments. This was also very troubling to the Monitoring Team since members of CCSSLC's Nursing Department articulated that they recognized there were significant problematic issues regarding the quality of the Comprehensive Nursing Assessments. As noted in previous reports, this area should be considered a priority for the Facility. It is crucial that nurses responsible for completing the quarterly/annual Comprehensive Nursing Assessments have the ability and understanding to analyze, summarize, and document health/mental health issues to determine whether the individuals under their care are actually making progress regarding their health status. The Facility should provide appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Regarding the nursing documentation for discharges/ individuals transitioning to the community since October 2012, a review of the nursing notes and Nursing Discharge Assessment Summaries for all nine individuals including: Individual #213, Individual #341, Individual #71, Individual #62, Individual #208, Individual #63, Individual #140, Individual #231, and Individual #69 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals.	

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		▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. No IPNs were provided in response to the following document request for any of the nine individuals transitioned to the community: "For the past six months, nursing documentation for individuals who have transitioned to the community, including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. Consistent with the findings from the previous six reviews, a number of problematic issues were found in the nursing documentation reviewed for all nine individuals, including: ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community; ▪ A significant lack of clinical assessments for clinical health indicators; ▪ A lack of an analysis of the individuals' health/mental health issues; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments; and ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals. Again, as noted in previous reports, it is essential that CCSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's transition/discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. A review of the Facility's Self-Assessment for Section M found that there was no mention that the Facility was reviewing this area. In addition, it was troubling to the Monitoring Team that the Action Plan for this provision included no action step addressing this consistent problematic area. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision. This was consistent with the Facility's finding in its Self-Assessment.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. CCSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement:	Noncompliance

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	interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	▪ The Facility reviewed the Nursing Care Plans (NCP) written for individuals admitted to building 503 for acute illnesses from 5/1/12 through 1/31/13, and found that compliance increased from 0% to 89% regarding the individualization of the care plans. The Facility's Self-Assessment noted that focused efforts in this area accounted for the increase in compliance, but the specific efforts implemented were not detailed in the Self-Assessment. In addition, since the Facility's findings did not comport with the findings of the Monitoring Team, it was unclear what criteria were used to determine compliance with this particular indicator. In addition, no data were provided to assess whether care plans were in alignment with the nursing protocols for the specific health issues, which is crucial to the quality of care of the individuals, especially during an acute illness. ▪ In addition, the Facility indicated that a review of the NCPs campus-wide from 9/1/12 through 1/31/13 found compliance scores ranging from 0% to 33% with limited improvement noted overall regarding the individualization of NCPs. The Self-Assessment indicated that focused efforts were being placed on the residential nurses. However, as noted above, there was no specific criteria included that was used to determine compliance or information provided regarding what efforts were being implemented in response to the Facility's findings. <u>Self-Rating:</u> The Facility's Self-Assessment indicated that: "based on the findings of the self-assessment, this provision is not in compliance." The records of 22 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues. Of the 22 individuals' Nursing Care Plans/Health Management Plans reviewed: ▪ Twenty (91%) were found to have a care plan addressing their high or medium risk health/mental indicator. Individuals who did not have a related care plan included Individual #224, and Individual #297. ▪ None (0%) of the nursing interventions contained in the 20 care plans 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	

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		when they should be considered for modification. The nursing interventions listed in the care plans reviewed were not in alignment with the nursing protocols addressing the specific health issues. ▪ None (0%) of the 20 HMPs were found to be clinically adequate. There was no indication that any type of nursing assessments was to be conducted addressing the specific health issue in alignment with the nursing protocols. The overall quality of the nursing interventions was poor in that they were generic, and non-specific to the individual's health care needs. ▪ None (0%) of the 20 HMPs contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 20 HMPs were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 20 HMPs, validating the implementation of the interventions was not possible, rendering them inadequate guides for the provision of care. For example, generic interventions such as "encourage fluids" could not be substantiated as being implemented. The Facility had a variety of formats of care plans that included Risk Action Plans, Acute Care Plans, and Integrated Health Care Plans due to the number of changes that had been made in the At Risk system. It was very concerning to the Monitoring Team to note the significant regression since the last review in the content of the care plans regardless of the format used. The Monitoring Team had noted the transition to the use of an integrated care plan as a promising step forward. In fact, the Facility's initial attempts at developing some integrated care plans in response to the Monitoring Team's past onsite reviews of individuals who had been hospitalized had resulted in very individual-specific plans that included appropriate clinical assessments in alignment with nursing protocols. However, the current findings of the Monitoring Team regarding this provision indicated that this promising process did not continue and that the previous problematic issues that existed regarding care plans were now essentially carried over into the current system. Specifically, some of the problematic issues identified in the previous Health Management Plans that were found in the current IHCPs included: ▪ The rationale for several risk levels did not include the needed clinical justification to support the designated level. Consequently, it was difficult for the Monitoring Team to determine the accuracy of the risk levels and the need for action steps addressing the health risks. ▪ The goals listed in the care plans reviewed did not address the etiology of the health problem as an objective clinical indicator to focus on. Consequently, most action steps found in the care plans did not address the underlying cause of the health issue and had no association with the goals listed. ▪ None of the nursing action steps found in the care plans were in alignment with the clinical assessments required by the nursing protocols for the specific health issues.	

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		▪ The action steps contained in the care plans frequently did not include specific information regarding who would implement the intervention, such as the RN, LVN, or Speech Therapist; how often they were to be implemented, such as on which shift if daily; noting consistently where they were to be documented; how often they would be reviewed; and/or when they should be considered for modification. Overall, most of the nursing action steps continued to be meaningless in that they were at times generic, and non-specific to the individual's health care needs. ▪ At the time of the review, the care plans reviewed were found to be clinically inadequate, lacked appropriate proactive action steps addressing the health indicator, and were not adequately individualized. ▪ The generic nature of the action steps prohibited validation that the step was actually being implemented. Regardless of the system and system changes made to the Facility's overall plans of care, it is crucial that the Facility address the lack of clinically adequate care plans for the individuals under their care. The Facility should develop and implement appropriate care plans based on priority and risk for all the individuals at CCSSLC Regarding nursing care plans addressing 33 episodes of contagious infectious illnesses including MRSA, Scabies, C diff, and Influenza A and B, for 27 individuals (i.e., Individual #210, Individual #338, Individual #326, Individual #161, Individual #89, Individual #234, Individual #153, Individual #282, Individual #263, Individual #223, Individual #235, Individual #209, Individual #87, Individual #310, Individual #335, Individual #355, Individual #10, Individual #4, Individual #65, Individual #353, Individual #156, Individual #357, Individual #270, Individual #314, Individual #292, Individual #189, and Individual #244): ▪ Of the 33 episodes, 17 (52%) were found to have had an acute care plan addressing the infectious issue. The individuals who did not have a care plan addressing the infectious issue were Individual #338, Individual #326, Individual #161, Individual #234, Individual #153, Individual #282, Individual #223 (two care plans missing), Individual #65, Individual #353, Individual #156, Individual #357, Individual #292, Individual #189, Individual #244, and Individual #335. ▪ Of the 17 Nursing Care Plan reviewed, none were found to be clinically adequate (0%). Consistent with past reviews, at the time of this review, CCSSLC had no system in place to ensure that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. It was very concerning to find that a significant number of individuals with	

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		contagious/infectious illnesses did not have care plans or adequate care plans addressing these illnesses. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. For progress to be made regarding this provision of the Settlement Agreement, the Integrated Health Care Plans should: ▪ Be in alignment with interventions and assessments from the nursing protocols; ▪ Be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the interventions will be reviewed and by whom; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized for plans of care. Overall, there had been basically no progress made addressing this provision of the Settlement Agreement. Unfortunately, since the last review there had actually been significant regression noted regarding the current care plans that were reviewed as compared to the initial integrated care plans that were being developed during past reviews. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. With regard to this provision, CCSSLC's Self-Assessment indicated the following: ▪ The documentation contained in the Facility's Self-Assessment indicated that since the last review, a number of training classes had been provided to nursing on a variety of different subjects such as deficits regarding documentation requirements that were found from death reviews conducted, Annual Skills Check-Off, Medication Cart Exchange procedures, and Medication Administration for Nurses. Although these trainings were positive steps, it was unclear to the Monitoring Team how these training classes related to this particular provision. In addition, although the Facility had conducted training regarding five new statewide Nursing Protocols in March 2013, which did address this particular provision, there was no mention of this found in the Facility's Self-Assessment for Section M.4.	Noncompliance

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		Self-rating: Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "Based on the findings of the self-assessment, this provision is in compliance. The majority of nurses have attended the training and the Medication Administration and Mosby Classes are on-going. We continue to enforce the implementation component." As noted above, although the training classes that were provided to the nurses since the last review were positive steps, there was no explanation provided in the Facility's Self-Assessment regarding how the training classes demonstrated that substantial compliance had been achieved with this requirement of the Settlement Agreement. In addition, the Presentation Book for Section M indicated that training had been provided to 99% of the nurses regarding the five new statewide Protocol Cards. However, there was no data presented in the Facility's Self-Assessment or Presentation Book indicating that nursing assessment and reporting protocols sufficient to address the health status of the individuals served were actually being implemented as the Settlement Agreement required. Also, there was no information provided that specifically addressed how the Facility was enforcing the "implementation component" reported in the Self-Assessment or data to indicate compliance with the implementation piece. Although the Facility indicated that the nursing protocols had been implemented, the Monitoring Team found little to no evidence that they were actually being used. In fact, essentially the same significant problematic issues were found for the current review regarding nursing assessments, care plans, and the overall nursing care and associated documentation as was found during the previous reviews. Specifically, the problematic findings found in the nursing documentation reviewed for Sections M.1 regarding nursing care for individuals admitted to a community hospital, Section M.2 regarding nursing assessments, Section M.3 regarding nursing care plans, and Section M.5 related to individuals with high-risk health indicators showed that the Facility was not implementing the nursing protocols. Since the Monitoring Team's last review, concerns related to the lack of nursing practices and care in alignment with the standards of care outlined in the nursing protocols had not improved as a result of any training that had been provided. In addition, the major concerns the Monitoring Team had regarding these consistent problematic issues, especially related to individuals with high-risk health indicators and their changes in status warranting hospital admissions were exemplified in a review of Individual #117's health care prior to his death in July 2012. Based on the documentation the Facility provided identifying risk ratings, Individual #117 was noted to be at high risk for aspiration, cardiac disease due to bradycardia with pace maker inserted on 5/24/12, fluid imbalance due to edema and low sodium levels, weight due to "dramatic weight loss," osteoporosis, falls, fractures, and polypharmacy.	

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		He was noted to be at medium risk for choking, respiratory compromise, gastrointestinal problems, constipation/bowel obstruction, circulatory issues, and challenging behavior. In addition, the documentation indicated that on 4/15/12, he had a G-Tube inserted for silent aspiration found from a modified barium swallow study. He had been seen in the Emergency Room on 5/22/12 for a laceration to his upper right eye. Admissions to the Infirmary since January 2012 included 4/10/12, 4/16/12, 5/11/12, 5/27/12, and 7/7/12 for G-Tube placement, bradycardia, pacemaker insertion due to bradycardia, and fever/azotemia (high levels of nitrogen-containing compounds). In addition, he had been hospitalized since January 2012 on 4/12/12, 5/10/12, 5/22/12, and 7/10/12 related to G-Tube placement, bradycardia and seizures, near syncope, bradycardia, hypotension, and unresponsiveness. In reviewing the documentation for Individual #117, a number of significant problematic issues were found regarding the care of this individual. Some of these problems included: ▪ Although a G-Tube was placed on 4/15/12 and the individual was not taking anything by mouth, the Comprehensive Nursing Assessment completed on 4/30/12 indicated that the last meal that nursing staff monitored was on 4/24/12, noting he tolerated meals and that: "Staff prompted him to eat slowly with smaller bites and to take sips of fluids between." ▪ The summary section of the Comprehensive Nursing Assessment dated 4/30/12 addressing High Risk for Choking/Aspiration did not indicate that a G-Tube had been placed, and noted that he "continues on a pureed diet, honey thick liquids with staff supervision." ▪ The Nutrition and Weight Management section on the Comprehensive Nursing Assessment, dated 4/30/12, addressing weight was left blank in spite of the individual having a 17.4 pound weight loss during the month of April 2012, and being designated as being at high risk for weight issues on the Integrated Risk Rating Form. The summary section of the Comprehensive Nursing Assessment, dated 4/30/12, did not mention any issues related to the individual's significant weight loss. ▪ Under the Braden Scale section of the Comprehensive Nursing Assessment, dated 4/30/12, nutrition was rated as "excellent" noting that the individual eats a balanced diet and no supplementation was needed. This was identical to the documentation found on the Comprehensive Nursing Assessment dated 1/2012. ▪ The summary section of the Comprehensive Nursing Assessment, dated 4/30/12, did not adequately address any of the high or medium health risks or changes in status that this individual had experienced during the quarter. In fact, the entire Health Risk review section was identical to the Health Risk review section contained in the Comprehensive Nursing Assessment dated 1/2012, and almost identical to the Comprehensive Nursing Assessment dated	

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		10/31/11. ▪ The Health Management Plans found in the Active Record addressing blepharoconjunctivitis, dehydration, pacemaker placement for bradycardia, seizures, skeletal fractures, gastrostomy/jejunostomy tube, and sinusitis were the basic template with little to no individualization for an individual with a significant number of health risks. ▪ None of the HMPs noted above were in alignment with nursing protocols. ▪ The Risk Action Plan, dated 1/5/12 and revised on 4/27/12, 5/31/12, and 6/14/12, included no interventions addressing nursing assessments for any of the individual's health risks in alignment with nursing protocols. ▪ The IPNs contained no consistent and regular nursing assessments to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, skin assessments, treatments provided, pain assessments, vital signs, lung sounds, oxygen saturations, bowel and urinary output, daily fluid input, assessments for hydration, bowel sounds and abdominal palpation. ▪ There were significant blanks found on the Infirmary intake and output forms for May and June 2012, and one additional Infirmary intake and output form that also had a number of significant blanks did not include the month and year. ▪ There were no regular nursing assessments addressing the individual's health issues in alignment with the assessments required by nursing protocols for an individual with several health risks and changes in status. ▪ Since there were no nursing assessments regularly conducted, changes in status could not be quickly recognized and responded to. ▪ When the individual was admitted to the Infirmary for fever and dehydration, there was no documentation from nursing indicating how nutrition was being provided and tolerated. ▪ There was no indication from the nursing documentation if the individual's daily intake of fluids and urine output was adequate. ▪ A review of a spreadsheet listing the recommendations generated from the Facility's Mortality Review for this individual, none of the above findings were addressed or even mentioned as problematic issues identified. Also, a review of an additional 11 individuals that were admitted to the hospital since the last review (i.e., Individual #127, Individual #182, Individual #155, Individual #326, Individual #321, Individual #340, Individual #245, Individual #305, Individual #357, Individual #167, and Individual #156) found similar problematic issues throughout the nursing documentation as those found in Individual #117's record (more detailed findings are provided with regard to Section M.1). These consistent problematic findings clearly did not support that the Facility had actually implemented the use of nursing protocols.	

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		From the Monitoring Team's review, there was no indication that nursing was actually using nursing protocols as part of a structured system to guide nursing practice and the associated documentation to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data was established to quickly recognize changes in health status; ▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status; and ▪ Appropriate and clinically adequate care plans were developed that outlined specific nursing interventions for specific health issues. Consistent with past reviews, the problematic findings from this review indicated that CCSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was in substantial compliance with this requirement, but this was not consistent with the findings of the Monitoring Team.	
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.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ As noted in more detail with regard to Section I, statewide revisions had been made to the At-Risk Individuals system. The Facility reported that competency-based training regarding the Enhanced Risk Rating system was provided on 10/4/12 and 10/5/12 with 14 of 14 (100%) of the required nursing staff in attendance. The Facility's Self-Assessment noted that the quality of this training was significantly improved. Several key components addressing issues such as data, supports, baselines, and specific clinical indicators that were not addressed previously were included in the most current training. ▪ In addition, the Facility Self-Assessment indicated that on 1/25/13, the Integrated Risk Rating Form was revised to include sections addressing the History, Current Supports, Current Status, Proposed Recommendations, Team Deliberations, Final Recommendations, and the Risk Rating. In January 2013, the Facility had implemented the revised IRRF. ▪ The Facility's Self-Assessment indicated that a review was conducted regarding the Integrated Risk Rating Forms and the Integrated Health	Noncompliance

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		Care Plans completed from 5/1/12 through 1/31/13 to determine if the IDTs started the assessment process as soon as possible but within five working days, if individuals were re-assessed within five working days in response to changes in an at-risk individual's condition, and if there was a tracking system to ensure completion of the assessments. In addition, the Facility indicated that a review of the Integrated Health Care Plans was conducted to determine if the plans contained consistent risk levels between the IRRFs and IHCPs, specific clinical indicators, implementation dates, the person responsible for implementation, the monitoring frequency, the location of documentation, the person responsible for review of progress/efficacy, completion dates, recommendations for further assessment if necessary as well as a number of additional indicators as detailed in Section I. Some of the data presented in the Facility's Self-Assessment looked promising regarding the explanations of how samples were selected as well as some of the Facility's findings that were similar to the Monitoring Team's findings regarding items such as the establishment of appropriate plans within 14 days of the plans finalization [0 of 4 (0%)]. However, from discussions with the CNE and Habilitation Therapies Director, the Facility recognized that the quality of the assessments and planning efforts was not being adequately audited and that some of the clinical disciplines would have to participate in the auditing process in order to address this issue. ▪ Although the Facility's Self-Assessment included some promising information regarding initial monitoring data regarding the At Risk system, there was no information included addressing the problematic issues found addressing the specific area of nursing related to this provision of the Settlement Agreement. <u>Self Rating</u> The Facility's Self-Assessment indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance. The data supports that the teams are performing an interdisciplinary assessment of services and supports after an individual is identified as at risk, however, they continue to need guidance when changes are necessary in response to changes in an at-risk individual's condition. The Enhanced Risk Process addresses these systemic issues; however, an insufficient amount of time has passed since its implementation (January 25, 2013) to allow an adequate analysis of the new process to be completed at this time."	

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		Consistent with past reviews, the findings from the Monitoring Team noted below indicated the documentation reviewed did not adequately address individuals' health/mental clinical health risks in alignment with the requirements of this provision. A review of records for 22 individuals determined to be at risk (i.e., Individual #9, Individual #333, and Individual #214 for aspiration; Individual #198, Individual #182, and Individual #224 for dental issues; Individual #74, Individual #165, Individual #142, and Individual #153 for weight issues; Individual #91, and Individual #313 for urinary tract infections; Individual #65, Individual #7, and Individual #270 for constipation; Individual #128, Individual #296, and Individual #321 for fractures; Individual #97, and Individual #255 for diabetes; and Individual #297, and Individual #191 for behavior issues) found that none (0%) included adequate nursing risk assessments that included individual-specific information that clearly justified the risk ratings assigned. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 22 individuals found that none of them (0%) contained an adequate assessment of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. A review of these 22 individuals' records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms. Although as noted with regard to Section I, the Monitoring Team found that there was an overall increase in some of the specific clinical information contained on the IRRF forms. However, for some of the areas that nursing was responsible for assessing and/or providing information, such as constipation, weight issues, cardiac, and falls, injuries and/or fractures, there was a lack of individual-specific information noted that made it difficult to determine the accuracy of the risk rating that was assigned. Consistent with the findings from previous reviews, the CNE reported that since the previous review, there had been no modifications or specific procedure implemented to address the nursing assessment process and the analysis of the identified risk indicators. Consistent with the findings from past reviews, the nursing assessments reviewed for the At-Risk individuals noted above did not adequately address their health risks. In addition, a review of the 22 records for these individuals determined to be at risk found there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%).	

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		▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plans had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, could not be verified. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need to encourage adequate fluids, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in 20 of the cases (91%). Individuals who had not had their IHCPs/Risk Action Plans integrated into their written ISPs included: Individual #224, and Individual #297. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. At the time of the review, the Facility had begun to implement the additional changes that had been made to the ISP and At-Risk process. However, the significant existing deficits in the current At-Risk system, especially the nursing components of the system regarding the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans, HMPs, and IHCPs still needed to be addressed. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals, and provide training and mentoring addressing this area. At the time of the review, the Facility indicated that they were not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	

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M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	As detailed below, the Monitoring Team conducted its own review of the requirements of this section. However, it also reviewed the Facility's Self-Assessment. In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ The Facility's Self-Assessment noted that the Medication Administration Observation form was revised in September and October 2012 with training completed for all nursing staff. The overall positive revisions included designating certain items on the tool as "essential elements" that if not completed appropriately by the nurse, would result in a failed observation, requiring immediate retraining and follow-up observations. Since the last review, training also was completed for all nurses regarding reading the Physical Nutritional Management Plan (PNMP) to the individual prior to the administration of medications. ▪ Although the Facility's Self-Assessment indicated that auditing data from the Medication Administration Observations from May 2012 through February 2013 showed an upward trend regarding the compliance scores for medication administration, the data could not be accurately interpreted since only one compliance score was presented for each month. Although the Self-Assessment did indicate problematic areas regarding the medication observations included the nurse referring to the PNMP prior to medication pass, and compliance with not crushing medications listed on the Facility's "Do-not-crush list," there was no data presented indicating if these issues were improving over the review period, especially since the Facility reported that training regarding the PNMPs had been provided. Regarding the Facility's self-rating, the Self-Assessment stated: "based on the findings of the self-assessment, this provision is not in substantial compliance. The data indicates improvements in medication passes. In January 2013, a system was developed for medication reconciliation." In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and review of the information contained in the Presentation Book for Section M.6 indicated that since the last review, the Facility indicated that the following steps regarding the Facility's overall medication administration system had been initiated: ▪ Thus far, the Facility had provided training regarding the statewide Medication Administration Competency class to 56% of the nurses at CCSSLC. The Monitoring Team's previous review of the curriculum found it to be exceptionally comprehensive.	Noncompliance

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		▪ A draft written procedure addressing the medication cart fill was developed and implemented by Pharmacy and Nursing. ▪ The Facility conducted a review of the completed Medication Excess/Shortage Forms and identified a number of problematic issues, such as the timeliness of sending the forms, legibility issues, and the need to include the individuals' complete names. ▪ The Facility developed and implemented a spreadsheet to track the results of the Medication Administration Observations of each nurse on campus. ▪ The Facility had initiated the monthly reporting of all internal pharmacy variances, noting that 80 variances were found in December 2012 and only 15 were found in January 2013. Although the steps forward discussed above included some very promising, and thoughtful interventions, at the time of the review, the Monitoring Team found that CCSSLC continued to have some significant problematic issues regarding its overall medication administration system as noted below: ▪ In December 2012, the Facility, in response to finding 933 excess medications that were unexplained and unaccounted for from the documentation on the Medication Administration Records (MARs), implemented a system to address medication reconciliation that included medication counts between shifts to timely identify excess or shortages of medications. The Facility reported that this procedure was initially implemented in four residences. However, during the week of the review, it had been implemented Facility-wide. The Facility reported that since the procedure was initially implemented, the number of unknown excess medications had decreased in January 2013 to 675. Although the resulting decrease in the number of unexplained excess medications was a positive outcome, it was alarming to the Monitoring Team that the significant number of excess medications that could not be reconciled was quite probably medications that had not been administered as ordered for the individuals at CCSSLC. The clinical ramifications of this issue could be staggering in that medications prescribed for medical issues such as seizures, constipation, hypertension, vitamin deficiencies, and skin conditions were noted to be among the many medications that were found to be in excess without explanation. ▪ The Facility's data indicated that the percent compliance from the Medication Administration Observations conducted from May 2012 through February 2013 was found consistently to be between 94% and 100%. However given that the Facility's data showed that 1608 unexplained medications were returned to the Pharmacy from December 2012 through January 2013, the high compliance scores regarding the Medication Administration Observation data was highly suspect. There was no indication at the time of the review that nursing was	

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		analyzing these obvious discrepancies between data and practice. ▪ Although at the time of the review the Pharmacy and Nursing had been focusing significant energy on systems related to the number of unexplained medications that were being returned to the Pharmacy each month, there was no indication that the Facility had focused efforts on determining if these unexplained excess medications had any impact resulting in changes in status for the individuals. For example, if seizure medications were being returned in large numbers, the Facility should have determined if a trend was occurring with increases in seizure activity. ▪ Although the Facility was spending much time reconciling the number of unexplained returned medications each month, the number of actual medication variances suggested that CCSSLC continued to have a significant problem regarding the under-reporting of medication variances. ▪ Although the Facility's data indicated a downward trend, there continued to be a significant number of MAR blanks from October through December 2012; 357, 119, and 110, respectively. A review of the medication variances (Category A-E) reported by the Facility indicated the following: ▪ October 2012 - 14 variances; ▪ November 2012 - 12 variances; ▪ December 2012 - seven variances; and ▪ January 2013 - 21 variances. Based on observations of medication administration at the Infirmary and Ribbon Fish 3, the following problematic issues were found. Specifically, the nurse did not: ▪ Check the correct position for the individual during medication administration. Although the nurse read the PNMP to the individual before administering the medications, he did not check the individual's wheelchair to ensure it was in the correct position in alignment with the PNMP. In fact, it was not in the most upright position as required; ▪ Assess lung sounds appropriately when an individual began to cough during administration of medications. Initially, the nurse spent only seconds listening to the individual's lungs with stethoscope over clothing, until prompted by the Nurse Educator to repeat the procedure with correction provided; and ▪ Give medications at eye level in alignment with instructions on PNMP; and ▪ Identify that the picture on the PNMP for positioning had a different wheelchair headrest than was actually on the individual's wheelchair, and this altered the individual's position.	

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		A number of problematic issues continued to be noted regarding the medication administration systems at CCSSLC. However, at the time of the review, the Facility was taking steps to review and implement strategies to address some of the problematic elements of the medication administration system. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets including the Medication Administration Observations. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a format and structure to critically review the overall medication system. The Monitoring Team found the Facility was not in compliance with this provision. The Facility's finding in its Self-Assessment was consistent with the Monitoring Team's finding.	

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

1. As previously recommended, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. (Section M.1)
2. As CCSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions, such as the Nursing Administration Coordinator position and the Nurse Case Manager Supervisor position. (Section M.1)
3. As previously recommended, the Facility should continue to implement and expand the use of nursing protocols to guide nursing practices. In order to ensure this occurs, mentoring of nurses should be offered in conjunction with the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group. Due to the number of individuals with complex medical needs at CCSSLC, this area should be considered a priority for Facility review, including the development and implementation of action plans addressing the significant deficits that exist in the nursing care. (Section M.1)
4. The Facility should analyze all monitoring data addressing Infection Control in order to better identify systematic and/or staff–related problematic trends that might be impacting the rates of infections at the Facility. (Section M.1)
5. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)
6. As recommended in past reports, additional expertise in Infection Control is needed to assist 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. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
7. Clinical staff, including nursing staff, should be involved in the review and analysis of Emergency Mock Code Drill data and data addressing the actual medical emergencies, and should participate, as appropriate, in the development and implementation of action plans to address any problematic trends identified. (Section M.1)
8. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments

from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. (Section M.2)

9. CCSSLC should review and revise its current nursing discharge/transition procedures and documentation requirements to ensure that upon an individual's transition from the Facility to the community, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
10. The Facility should develop and implement appropriate care plans based on priority, and risk for all individuals at CCSSLC. (Section M.3)
11. Nursing, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
12. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals and provide training and mentoring addressing this area. (Section M.5)
13. The Facility should continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of actions aimed at long-term resolutions. (Section M.6)
14. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, such as continuing to conduct regular reviews of the Medication Administration Records, and review the discrepancies between data sets including the Medication Administration Observations. (Section M.6)
15. Further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. (Section M.6)
16. The Facility should continue to consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. (Self-Assessment)

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 Policies, procedures and/or other documents addressing the provision of pharmacy services; o Any pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All Drug Utilization Evaluations (DUE) reports completed since last Monitoring Team visit, including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results; o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing poly-pharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments since the Monitoring Team's last visit; o DUE calendar for next 12 months, including specification whether fiscal year or calendar year; o For Quarterly Drug Regimen Reviews, for all individuals the Facility serves, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one year period (beginning 1/1/12); o For Quarterly Drug Regimen Reviews two most recent per residence that have been completed with physician signatures and dates, including for anticholinergic justification, documentation or document (with date) of risk/benefit analysis completed in relation to side effects; and for poly-pharmacy justification, document (with date) in which rationale was discussed for poly-pharmacy for psychotropic and non-psychotropic poly-pharmacy. Information for the following individuals was submitted: Individual #61 9/19/12, 12/31/12; Individual #267 9/6/12, 12/13/12; Individual #273 8/20/12, 12/4/12; Individual #313 7/18/12, 10/26/12; Individual #40 9/26/12, 12/26/12; Individual #153 7/18/12, 10/25/12; Individual #276 8/20/12, 12/4/12; Individual #274 8/20/12, 12/4/12; Individual #53 9/5/12, 12/9/12; Individual #349 7/17/12, 10/26/12; Individual #321 9/19/12, 12/31/12; Individual #99 7/19/12, 10/26/12; Individual #228 10/3/12, 1/15/13; Individual #291 10/3/12, 1/17/13; Individual #234 9/27/12, 1/3/13; Individual #92 9/10/12, 12/17/12; Individual #308 9/18/12, 12/28/12; Individual #332 9/20/12, 1/2/13; Individual #42 9/20/13, 1/2/13; Individual #329 10/9/12, 1/24/13; Individual #245 8/3/12, 11/14/12; Individual #10 7/9/12, 10/26/12; Individual #191 9/18/12, 12/28/12; and Individual #72 9/27/12, 1/7/13; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders for the following individuals for recommendations accepted: Individual #285 1/24/13, Individual #31 1/25/13, Individual #200 1/25/13, Individual #194 1/25/13,

	Individual #3 1/31/13, Individual #282 1/25/13, Individual #86 1/25/13, Individual #211 1/28/13, Individual #111 1/29/13, and Individual #91 1/29/13. o For 10 most recent QDRRs in which recommendations were made and not accepted, copies of IPN or other entry indicating reason for non-agreement, for the following individuals: Individual #147 1/30/13, Individual #58 1/25/13, Individual #4 1/30/13, Individual #9 1/30/13, Individual #304 1/31/13, Individual #355 1/31/13, Individual #310 1/31/13, Individual #367 1/28/13, Individual #333 1/28/13, and Individual #136 1/30/13; o All "single patient intervention reports" in WORx system since the Monitoring Team's last visit; o Since the Monitoring Team's last visit, a copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with "single patient intervention reports"; o For the past six months, any adverse drug reaction reports (ADR) completed; o Policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors variances per month for the prior 12 months by error type, nurse, residence, shift, unit, individual, category of severity, error mode, including graphs, charts (per month, per quarter), and analysis reports, as well as corrective action plans, root cause analysis summaries, etc.; o Copies of the last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Copy of any communication between Pharmacy and Nursing Department concerning medication errors/variance (e.g., emails, memos, etc.) since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Any policies, procedures and/or other documents addressing medication administration; o List of antibiograms per month for last six months by residence; o A schedule of when Quarterly Drug Regimen Reviews are conducted by residence/unit; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #238 7/7/12, 7/23/12 4:15PM, 7/23/12 5:40PM, 11/2/12, 12/27/12, 12/28/12, 1/11/13, 1/24/13 4:21PM, 1/24/13 5:05PM, 1/30/13; Individual #147 7/4/12, 7/6/12 3:00PM, 7/6/12 11:15AM, 7/8/12, 8/16/12; Individual #172 10/22/12, 11/14/12 5:26PM, 11/14/12 11:40PM, 11/15/12, 1/15/13, 1/16/13; Individual #4 8/20/12, 9/24/12; Individual #169 11/19/12; Individual #275 8/21/12, 9/20/12, 12/2/12, 1/15/13; Individual #144 1/24/13; Individual #40 9/29/12, 11/6/12, 11/19/12, 12/25/12, 1/27/13; Individual #109 7/29/12, 9/10/12, 9/11/12 09:51AM, 9/11/1210:25AM; Individual #253 6/6/12; Individual #191 8/12/12, Individual #141 6/4/12, 7/12/12, 8/7/12, 9/14/12, 9/20/12, 10/8/12, 10/12/12, 11/4/12, 12/19/12, 1/29/13, and 1/30/13; o Any trend analysis of chemical restraint use (e.g., graphs, etc.);

	o For each database maintained on the use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months, with the name/source of the database clearly identified; o For nine new orders involving drug-drug interactions, copies of orders, copies of change in orders, handouts, patient intervention reports, copies of serial computer screen shots for each step or pharmacy medication label at time indicating change in order. Submitted documents were for the following nine individuals: Individual #238, Individual #297 12/4/12, 9/18/12, Individual #158, Individual #46, Individual #128, Individual #233, Individual #357, and Individual #234; o For two new orders involving potential allergic reactions, copies of orders, copies of change in orders, handout patient intervention reports, copies of serial computer screen shots for each step or pharmacy medication label at time indicating change in order. Submitted documents were for the following individuals: Individual #300, and Individual #233; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of orders, copies of change of orders, handouts, patient intervention reports, copies of serial computer screen shots for each step or pharmacy medication label at time indicating change in order. Submitted documents were for the following individuals: Individual #238, Individual #103, Individual #210, Individual #300, and Individual #329; o For five new orders in which labs are reviewed/monitored, copies of orders, copies of change of orders, handouts, patient intervention reports, copies of serial computer screen shots for each step or pharmacy medication label at time indicating change in order, relevant lab and computations completed by pharmacy. Submitted documents were for the following individuals: Individual #57, Individual #287 10/9/12, 11/30/12, Individual #25, and Individual #202; o For three new orders for which there was potential for significant side effects, copies of orders, copies of change of orders, patient intervention reports, copies of serial computer screen shots for each step or pharmacy medication label at time indicating change in order, including any written documentation/ information provided to the PCP and response of the PCP. Submitted documents were for the following individuals: Individual #372, Individual #3, and Individual #5; o For the self-assessment process: list of monitoring/audit tools used; any inter-rater reliability data obtained/analyzed for the audit/monitoring review; o For the self-assessment process; list of databases utilized (other than audit information); o Medication Variance Identification and Review document, with training roster attachment; o Nurse ADR training; o Documentation of PCP ADR training; o Sample ADR report; and o Presentation Book for Section N. ▪ Interviews with: o Gary Frech, RPh, Pharmacy Director o Janet Way, RPh, PharmD ▪ Observations of:

	o Pharmacy and Therapeutics Committee meeting 4/3/13 o Medication Variance Meeting 4/3/13
	Facility Self-Assessment: For Section N, in conducting its self-assessment, the Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: ▪ Several monitoring tools had been created. The monitoring/audit tools the Facility used to conduct its self-assessment included: QDRR responses tracking tool, QA tool for New Order Review, QDRR monitoring tool, and QDRR laboratory audit form using psychotropic and anti-epileptic lab monitoring matrix. The Pharmacy Department developed and implemented an internal QA review of the new order process. The Pharmacy Department provided data indicating that from September 2012 through January 2013, each month, 20 orders were audited for processing by the Pharmacy Department. Recorded in graph form were the results of the five months of data for each of the categories of new orders. Compliance per month ranged from 65 percent to 85 percent. It was noted that the graph had no title or key The Pharmacy Department developed and implemented a QA process in tracking various aspects of the QDRR process. Submitted was a sample from five residences. QDRRs for 75 individuals from these residences were tracked by date of last QDRR review, date of most recent QDRR review, date of PCP review, date of psychiatrist review if applicable, whether recommendations occurred, and whether the PCP/psychiatrist agreed with the recommendations and orders were generated. An additional monitoring audit, with two separate components had also been developed and implemented. For one component (untitled), QDRR review included the required monitoring of lab and other diagnostic tests (e.g., EKGs, etc.), and whether indicated lab values were included in the QDRR. A sample of this audit was provided from September 2012 and included 10 QDRRs. The audit appeared to be thorough and detailed. An additional second component was entitled "Pharmacy QE QDRR assessments." This reviewed 20 QDRRs for compliance with each of the subsections of the QDRR: metabolic risk, benzodiazepine, anticholinergic burden, indication for atypicals, poly-pharmacy, MOSES, DISCUS, Pharmacist recommendations and additional notes. This review audited with a "Y/N/NA" review and provided a broad perspective of completion for each of the subsections of the document. This provided the Pharmacy Department with rapid identification of areas needing improvement. This audit process was repeated each month, and data was submitted for October 2012 through January 2013. Additionally, the Pharmacy Department tracked QDRR completion according to their interpretation of the guideline. This included the due date of the QDRR, based on the prior QDRR due date, the date of completion, and whether this occurred within the agreed upon timeframe of seven days prior to 14 days after the prior QDRR due date. This was a continuously updated document spanning the prior year. It was noted that the criteria did not exactly match the agreement between the State Office and the

	Monitors. ▪ These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement for Sections N.1, N.2, N.3, and N.4. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations for other subsections. ▪ The monitoring tools included adequate methodologies, such as record reviews, review of specific documents such as QDRRs and new drug order process and documentation. ▪ The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. ▪ The staff pharmacist was responsible for completing the audit tools. Some of the other relevant data sources were used to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as the Avatar database for lab values and chemical restraint use, the chemical restraint trend reports from the Psychology Department, the drug regimen review database tracking timeliness of completion, WorX software for new orders, and medication errors utilizing Excel. ▪ The quality of the data maintained in the databases was noted to be complete and accurate. ▪ Examples of databases/data sources that were not considered included tracking the timeliness and content of the pharmacy section of the chemical restraint form, and the timeliness of the PCP and psychiatry response to the QDRR. The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ▪ Presented findings consistently based on specific, measurable indicators. ▪ Consistently measured the quality as well as presence of items. The Facility rated itself as being in compliance with the following sub-sections of Section N: N.2, N.4, N.5, and N.7. This was not fully consistent with the Monitoring Team's findings. The Facility data identified areas of need/improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying for example various causes of unexplained excess medications. However, it did not identify the need to track timely response of the PCP and psychiatrist to the QDRR. It did not follow the agreed upon methodology for Section N in monitoring timely completion of the QDRR each quarter.
	Summary of Monitor's Assessment: The Pharmacy Department had a new departmental Director. There was also a new Clinical Pharmacist in the department since the Monitoring Team's last visit. Of importance, the Pharmacy Department had made inroads into the problem of unknown excess returns of medications. The Pharmacy Department revised the reporting system for medication variance to include

	many aspects of dispensing and administering medication. Along with this had been numerous approaches to assist the Nursing Department in resolving medication variances. These had included such projects as twice weekly medication cart exchanges, and reducing floor stock. The system had begun to capture data for medication excesses due to furloughs and refusals of medication. Although this area remained a challenge, much progress had been made. There remained challenges for new orders. Patient intervention reports in the WorX system were not always entered with sufficient information to determine closure. Some aspects of the QDRR reports were consistently of high quality, while other aspects needed additional information. PCPs and psychiatry needed to demonstrate timely review of the QDRR. The Pharmacy Department was not completing the chemical restraint forms in a timely manner. The Pharmacy also needed to record the medication, dose, and route of the medication listed on the chemical restraint form, as this was often incomplete. An entry concerning effectiveness of the chemical restraints would lead to quality recommendations. Adverse Drug Reaction training needed improved documentation for direct support professionals, as well as new medical and nursing staff. The Facility was found to be in substantial compliance with Section N.2, related to timely completion of QDRRs and laboratory reviews; Section N.7, the section focusing on drug utilization evaluations; and Section N.5 related to monitoring of side effects for psychotropic medication. Other areas remained a challenge, although it is anticipated that the Pharmacy Department will make important strides in the months ahead.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose	The Pharmacy Department staffing included a Pharmacy Director, one Pharm D/RPh, two other staff Pharmacists (RPhs), and three Pharmacy Technicians (CPhTs). "Patient intervention" entries for new orders entered into the WORx software program were submitted for review. A total of 122 patient intervention entries were submitted. The following lists the number of patient intervention entries generated per month: ▪ August 2012 - seven; ▪ September 2012 – five; ▪ October 2012 - eight; ▪ November 2012 – 38; ▪ December 2012 – 44; and ▪ January 2013 – 20. Interventions were broken down into several different categories. The categories and numbers of patient interventions for each category follows: ▪ Interaction/Compatibility Intervention – 10; ▪ Activities - one;	Noncompliance

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	adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	▪ Allergy/Disease State Contraindication – two; ▪ Change in Dosage Form - one; ▪ Dose reduction – three; ▪ Duplicate/Unnecessary Therapy – two; ▪ Lab Monitoring – two; ▪ Order clarification /confirmation – four; ▪ QT prolongation – one; ▪ Side effects – three; ▪ Therapeutic consultation – one; and ▪ Discontinued medication – one. This totaled 31 of 122 (25%) patient interventions. There was no classification for the other 91 (75%) patient interventions. For 31 patient interventions, no information was provided concerning the medication, dosage, or pharmacy concern. The patient intervention system is valuable in assisting pharmacy communication with the PCP, and documenting the exchange of information. It is recommended that all patient intervention notes include the medication and dosage, as well as the concern, with documentation of the content of the communication to the PCP and the response from the PCP. Categorization was also problematic. A majority of the patient interventions were not categorized. If they had been, it would assist the Pharmacy in providing additional information for potential QA monitoring. It would provide information as to the type of intervention or concern most apt to lead to an order change or additional orders. This would then provide an opportunity to provide in-service education to PCPs as areas needing education were identified. Each patient intervention note should be categorized. However, there also appeared to be too many categories. It would be important to consolidate the many categories into a smaller selection that could be applied to the majority of patient interventions. This area was considered noncompliant. A sample of 24 new prescriptions was reviewed. The following summarize the results: ▪ Nine new orders were submitted for nine individuals for which Pharmacy found concerns with drug-drug interactions with the current drug regimen. A computer screen shot of the order was submitted for eight of nine (89%) individuals. For seven of eight (88%), a copy of the patient intervention form was submitted. For one individual, a patient intervention form was not applicable. A handout was provided to the PCP for seven of eight individuals. It was not applicable for one individual. A change in an order or an additional order occurred for seven of eight individuals. No change in order was submitted	

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		for one individual for which an order was indicated, and no change in order was indicated for one individual. Based on this information, adequate documentation of the new order process for drug-drug interaction screening and follow-up occurred in eight of nine (89%) submitted cases or no follow-up was needed. This area approached compliance of 90%. ▪ Two new orders were submitted in which allergies were reviewed and determined to be a concern by the Pharmacy. A computer screen shot of the order was submitted for two of two (100%). A copy of the patient intervention was submitted in two of two (100%). As a result of the pharmacy review, there was a documented change in order for two of two (100%) orders. Based on this information, adequate documentation of the new order process for allergies occurred in two of two (100%) of submitted cases. This area was compliant. ▪ Three new orders were submitted in which significant side effects were reviewed by Pharmacy and determined to be a concern. A copy of the order was submitted for three of three (100%). A screen shot or copy of pharmacy label indicating pharmacy processing was submitted in one of three (33%). The Pharmacy noted that the software did not alert the Pharmacist to potential side effects of medications and this category was dependent on pharmacy knowledge to identify potential significant side effects, making the screen shot a less valuable documentation process in identifying side effects. The Pharmacy also noted that only three new orders were submitted, because only three orders were found with sufficient documentation. A handout reviewing clinical information was sent to the PCP in zero of three. Laboratory testing was not applicable for three of three orders. A patient intervention note was submitted for three of three (100%). Evidence of an order change or an additional order was submitted in three of three (100%). In summary, for these three new orders submitted, three (100%) had adequate documentation concerning side effect review/collaboration with the PCP ▪ Five new orders were submitted in which the Pharmacy reviewed current laboratory results and identified the potential need for further testing during initial review. A copy of the order was submitted for five of five (100%). A copy of the screen shot or pharmacy label was submitted in four of five (80%). A copy of the patient intervention was submitted in one of one (100%). It was noted that a patient intervention report was not applicable for four cases. New orders were written for one of one (100%) based on communication with the PCP. Lab data was submitted in three of three (100%) with calculations completed, and lab data was ordered for two of two (100%) additional cases. Documentation was adequate for lab monitoring of new orders in four of five (80%) of cases. This area was not in compliance, as compliance threshold was considered 90%. ▪ Five new orders were submitted in which Pharmacy had concerns about the potential need for dosage adjustments. For five of five (100%) new orders, a	

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		copy of the order was submitted. For four of five (80%) orders, there was a copy of the screen shot order or pharmacy label submitted. For four of five (80%), there was documentation that the PCP was contacted. A copy of the patient intervention was submitted for this in two of five (40%) orders. A change of order based on pharmacy review and PCP contact occurred in five of five (100%). In summary, there was adequate documentation of the process in two of five (40%). This area was not in compliance, as compliance threshold was considered 90%.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A schedule of completed QDRRs was submitted for the prior year, along with the due date, and date of actual QDRR completion. Each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR's date of completion. The time period for review was from 7/1/12 through to 1/23/13. During that time 591 QDRRs were completed. In April 2012, the parties and the Monitors agreed on a methodology for calculating timeliness of QDRR completion. The Pharmacy Department did not have a copy of these guidelines. Two timelines were addressed in the guidelines. The quarterly due date was every three months, the same calendar day of the month (e.g., 3/1, 6/1, 9/1, and 12/1) every three months of the year. The Facility was to establish this for each individual. The other parameter was the window of time allowed for completion of the QDRR. This was agreed upon as seven days prior to the due date through 13 days after the due date. It was noted specifically in the guidelines that completion of the QDRR 14 days after the due date was considered delinquent. The Pharmacy submitted a grid that included a 14-day window rather than the 13-day time period. For the time period July 1, 2012 through January 23, 2013, 591 QDRRs were completed. These were compared to the due dates submitted for these QDRRs. The due dates used the three-month interval and the same calendar day of the month in determining due dates. It was determined, that of the 591 QDRRs completed, 572 (97%) were completed in a timely manner. When reviewing the timeliness of the most recent QDRRs completed, for the time period of January 1, 2013 through January 23, 2013, there were 81 QDRRs completed from January 8, 2013 through February 3, 2013. Compliance was 74 out of 81 (91%). This indicated a worsening trend in timely completion of the QDRRs, although remaining above the compliance threshold of 90%. As an observation, the earlier months demonstrated that many QDRRs were completed within three days prior to or after the end of the review period. The most recent data from January 2, 2013 onward indicated a shift in when the QDRRs were completed. There were no QDRRs completed prior to the end of the review period or on date the review period ended. All were completed after the end of the review period. For days six	Substantial Compliance

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		through 13 after the end of the review period, the numbers of QDRRs completed was as follows: ▪ Day 6 post end of the review period - three QDRRs; ▪ Day 7 post end of the review period – eight QDRRs; ▪ Day 8 post end of the review period – zero QDRRs; ▪ Day 9 post end of the review period – zero QDRRs; ▪ Day 10 post end of the review period - four QDRRs; ▪ Day 11 post end of the review period - 13 QDRRs; ▪ Day 12 post end of the review period - 10 QDRRs; and ▪ Day 13 post end of the review period - 36 QDRRs. In order for the system to work, the Facility should consider mechanisms to ensure that these later completion dates did not become the norm and result in QDDRs not being completed timely. A sample of 24 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Laboratory information was submitted as part of 24 of 24 (100%) QDRRs. ▪ The lab results did include exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (e.g., most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ 24 of 24 (100%) QDRRs with labs had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab or in the recommendation section. ▪ The lab testing completed, and the frequency with which laboratory testing was completed did indicate that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. The Facility was found to be in substantial compliance with this provision, because at least 90% of the QDRRs had been completed timely, and included the relevant information related to laboratory results. However, the Facility is cautioned to rectify the issue with regard to its calculations related to the agreed-upon methodology for defining quarterly review periods and due dates.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical	This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, poly-pharmacy, and monitoring the metabolic and	Noncompliance

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	practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed, selected pages of restraint documentation for 51 chemical restraints used from 6/4/12 to 1/30/13. These are listed above in the documents reviewed section. On further review of these documents, the submitted chemical restraint documentation indicated that 10 of these were for medical/dental sedation, and were removed from the total. The reason for including these in the emergency chemical restraint documentation was unclear. This left 41 individuals with chemical restraints during this time period. For the 41 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The results might have been affected by the lack of completeness of the documentation submitted, as in most instances, only selected pages were submitted from the Restraint Checklist document. There were also two sets of data submitted, an earlier version with eight individuals listed. The information from earlier and later versions was reviewed for consistency. Some of the irregularities between the two versions noted are discussed below. The following summarizes the review of the pharmacy section of these documents: ▪ Of the 41 chemical restraint forms, 39 forms (95%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in three of the 41 (7%) chemical restraint forms completed. This was considered important, because the pharmacy was asked to include recommendations, which would require information concerning effectiveness. ▪ Side effects and adverse effects were noted in 29 (71%) of the completed chemical restraint forms. There were irregularities with this indicator. For one individual, the pharmacy recorded there were no side effects, but the psychiatrist indicated there were side effects. For one indicator, the earlier pharmacy report included side effects, but the later version did not. ▪ A discussion of drug/drug interactions was noted in 20 of 41 (49%) completed chemical restraint forms. There were several instances in which other medications were listed, but it was not clear if these were also chemical restraints or routine medications. For one case, in which later and earlier versions were submitted, one medication was listed (Zyprexa) and the later listed (Droperidol). The reason for the discrepancy was not clear. For another individual, the earlier version listed three medications, and the later version did not list any medications. It was also noted that there were several reports in which the route was documented as both PO and IM. There were three instances in which the submitted documents did not include the medication. For some	

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		reports, when more than one medication was given, important information was not included, doses were given without names, and names of medications were given without doses. It is recommended that the pharmacy section include the name of the medication, dosage, and route, and that the Pharmacy Department correct the report for omissions and errors. The former report system included the medication and dosage with the pharmacy section, but it appeared to have been discontinued. ▪ There were 12 statements that were considered recommendations. ▪ The range of time for completion of the forms was from one to 167 days. There were some discrepancies in completion date of the earlier and later versions. For two of the earlier versions, the completion date was four days each. For the later version, the days to completion was 70 days for one and 159 days for the other. For two individuals, the date of review was documented as occurring prior to the date of the restraint. The Psychiatrist also had a designated space for completion of the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documented showed: ▪ Of the 41 completed, there were 39 of 41 (95%) forms for which the psychiatry comment section was completed. ▪ For 41 of the chemical restraints used, there was a description of the behaviors and prior steps taken by the IDT/psychologist in zero of 41 (0%). ▪ For 39 of 41 (95%), clinical justification was documented. ▪ Side effects and drug interactions were mentioned in 37 of 41 (90%) reviews. ▪ Effectiveness was documented in zero of 41 cases (0%). ▪ There were seven recommendations documented. ▪ The range of time for completion of the forms was from one to 167 days. For two individuals, the date of review was documented as occurring prior to the date of the restraint. <u>Polypharmacy</u> Of the 24 QDRRs reviewed, polypharmacy was noted in nine reviews. Results of the Monitoring Team's review are as follows: ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in nine of nine (100%). ▪ Clinical justification for the use of polypharmacy (i.e., versus each medication) was addressed in six of nine (67%). Examples of justification could include the following: for multiple seizure medications, neurology clinic notes with date of visit confirming the continued need for the poly-pharmacy, or reference to the polypharmacy committee minutes with a specific date, with comment by the pharmacy that there was sufficient information to justify polypharmacy (for	

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		instance, a prior reduction had resulted in increased psychiatric symptoms). Such brief entries would provide evidence for justification, and indicate that the Pharmacist agreed that the evidence was sufficient for justification. ▪ Potential interactions with other drugs or food/side effect risk were reviewed in nine of nine (100%) ▪ For five of nine (56%), the QDRRs reviewed whether monitoring/evaluation had occurred of the effectiveness of the drug regimen. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in three of the 24 QDRRs. ▪ Of these, three of three (100%) documented justification with appropriate diagnoses; and ▪ Three of three QDRRs (100%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 24 QDRRs, all 24 (100%) were screened for medications associated with potential, significant anticholinergic side effects. Fourteen QDRRs identified medications with significant anticholinergic effects. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 14 of 14 (100%) of cases with this medication prescribed. ▪ 10 of 14 (71%) documented clinical justification of the use of each of the medications contributing to anticholinergic load and reference was made to the document discussing risk/benefit of the medication. ▪ One of 14 (7%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 24 QDRRs reviewed, 15 listed atypical antipsychotic medication. Of these, 15 of 15 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). The Facility remained out of compliance with this provision. In addition to problems with timeliness, the content and quality of the Pharmacy and Psychiatry Departments' reviews of chemical restraints required improvement. In addition, some of the components of the Pharmacy's review of polypharmacy as well as anticholinergic monitoring required attention.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical	Review of 24 QDRRs showed the following: ▪ Of the 24, 24 (100%) QDRRs included the PCP signature. ▪ Of the 24, 24 (100%) included the date the PCP reviewed the document. ▪ There were 15 recommendations from 13 of 24 QDRRs that were considered	Noncompliance

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	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.	clear and helpful. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 13 out of 13 (100%) QDRRs. o Agreement was documented in eight out of 15 recommendations. o There was disagreement by the PCP for seven of 15. QDRRs for seven of seven (100%) included a note of justification and plan when there was disagreement. ▪ The PCP responded within 14 days of the QDRR being completed by pharmacy in 20 of 24 (83%) QDRRs. ▪ Psychiatry reviewed the QDRR when there was poly-pharmacy due to psychotropic medication. A psychiatrist reviewed 15 of 24 QDRRs. o Agreement was documented in two of 15 (13%). o The area/box indicating agreement or not was left blank in seven of 15 (47%). o Agreement or not was not applicable for the remaining six of 15 (40%). ▪ The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in seven of 15 (47%) QDRRs. To determine if the recommendations agreed upon were actually acted upon, the Facility submitted 10 QDRRs completed in January 2013, with evidence from the active record that the recommendations had been completed (i.e., orders had been written). In the sample of 10, nine (90%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted 10 QDRRs completed in January 2013, in which the PCP did not agree with a recommendation. In 10 of 10 (100%) QDRRs, the response, rationale, and plan were included. The Facility remained out of compliance with this provision. In addition to problems with the timeliness of the PCPs' and Psychiatrists' reviews of the QDRRs, Psychiatrists were not indicating agreement or not with the recommendations, with follow up justification if applicable.	
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.	As discussed with regard to Section J.12, this provision of the Settlement Agreement and the Health Care Guidelines mandate systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this side effect monitoring also includes the latency between the time the nurse completed the exam, and the documentation was reviewed and signed by the prescribing physician.	Substantial Compliance

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		Review of the sample of the records of 18 individuals prescribed psychotropic medication indicated the MOSES evaluation was current (completed within the last six months and had been performed at least every six months) and present for all of the individuals in this sample (100%). The records of the 18 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 17 of the 18 individuals (94%). The one individual for whom documentation of the review by the prescriber was inadequate was Individual #318. The second page for all the MOSES evaluations in the record was missing, and that is where the date of the review by the prescriber is entered into the record. Thus, there was insufficient documentation to confirm that the MOSES evaluations were reviewed in a timely manner for this individual. The purpose of the DISCUS was to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of individuals indicated that only 16 of these individuals were prescribed antipsychotic agents that would require monitoring with the DISCUS. The documentation contained in the records of these 16 individuals indicated that the DISCUS had been completed as specified for all of these individuals (100%). These evaluations had been reviewed and signed in a timely manner for all of these individuals (100%). The results indicated that the Facility had maintained the progress noted in prior reviews. The date the MOSES and DISCUS evaluations were performed was recorded in the Psychiatric Quarterly Review documentation, as were the results for each and whether or not an additional action was required. The presence of any significant side effects, as well as the action required, would be discussed in the section of this document, which represented the Psychiatrists' Narrative Summary. Each Quarterly Review contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES are also necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who also were receiving antipsychotic medication. A list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals who were receiving Reglan, but not also	

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		prescribed psychotropic medication. The rationale for this distinction was that the nurses in the individuals' residences administered the evaluations for these individuals, rather than the Psychiatric Nurses. This process indicated that, as of 4/1/13, ten individuals were receiving Reglan, but were not prescribed medication for a psychiatric disorder. The following sample of four individuals (40%) who fit the above criteria was selected, and included: Individual #113, Individual #205, Individual #270, and Individual #137. The review of the records related to the MOSES evaluations for this group of individuals indicated that the examination had been performed every six months as required for three of the individuals in this sample (75%). There was a gap in the MOSES forms from 3/15/12 to 3/4/13 for Individual #137. All of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner (100%). The same sample of individuals receiving Reglan was used to evaluate the completion of the DISCUS. The results of this review indicated that the DISCUS evaluations were completed every three months as required for three of the four individuals (75%). The documentation indicated that the prescribing physician had reviewed three of the four evaluations in a timely manner (75%). The results for Individual #137 were compromised by the fact that the second pages of the DISCUS forms that contained both the date and signature of Nurse completing the evaluation, as well as that of the prescriber were missing. The front pages of two DISCUS forms provided for this individual indicated that the prior examination had been completed on 12/12/12 and 9/3/12, which would suggest that the examinations were being completed on schedule. However, without the signature pages, it is not possible to confirm this. During the onsite review, a member of the Monitoring Team also inquired about the degree of training that the Unit Nurses received with regard to performing the DISCUS evaluation. The Psychiatry Team indicated that all of the nurses receive both initial training as well as annual updates. This training was quite extensive and included both the review of videotape, as well as a required post-training competency test to assess skill acquisition. The Facility's Psychiatry Nurses were instructors for the training. In order to verify that the training was taking place, attendance for the prior year was reviewed. The Psychiatric Nurses also supplied the results of post-training tests and the DISCUS evaluations that the Nurses conducted after viewing the videotapes to illustrate they were able to utilize the correct methods for performing the evaluations. The content of the training materials, the documentation of attendance, and the production of the testing materials/results indicated that the Unit Nurses were receiving adequate training to competently complete the DISCUS evaluations for those individuals prescribed Reglan.	

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		The MOSES evaluation material has detailed instructions on how to conduct the evaluation embedded into the actual testing material. This evaluation was designed for completion by staff with a nursing degree. The continued finding of substantial compliance for this provision is based on the fact that the DISCUS and MOSES were both completed as required and reviewed in a timely manner for 94 to 100 percent in the sample of the individuals prescribed antipsychotic medication. For individuals prescribed Reglan, problems were noted for only one individual each for MOSES and DISCUS reviews.	
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.	Starting 2/22/13, training of nurses occurred, however, a completion date was not provided. Ninety-five of 96 nurses (99%) had been trained in the nursing responsibilities of ADR, the location of the ADR form, and how to complete the form. On 11/16/12 during an Integrated Clinical Services meeting, the PCPs were trained. The Clinical Pharmacist provided the in-service and reviewed the policy on ADRs. No roster of names was provided. However, from the meeting minutes, at least two of the PCPs trained were no longer at CCSSLC. It is recommended that a system of in-service to new PCPs be created that tracks training of ADR policy and procedure in the Medical Department. There was no information concerning new employee training or training for direct support professionals on how to identify an ADR. Four ADRs were reported in the prior six month and the following concerns were reported: ▪ Lisinopril and facial swelling, reported 8/21/12; ▪ Cymbalta and skin rash, reported 9/18/12; ▪ Vancomycin and skin rash, reported 12/27/12; and ▪ Amoxicillin and rash, reported 1/9/13. Four these four incidents, “Adverse Drug Reaction Reporting Forms” were submitted. For each, a Naranjo Probability Score was provided and the PCP completed the classification/criteria for assessment of severity of the adverse drug reaction. For all four reporting forms, of concern, the section for P&T Review and Recommendation was left blank, and there was no information concerning whether the adverse drug reaction was considered a Food and Drug Administration reportable event. The January 2013 P&T Committee meeting minutes indicated that three possible ADRs were reviewed for Cymbalta, Vancomycin, and Amoxicillin. One was considered a doubtful ADR as the medication was continued and the adverse effect (rash) resolved.	Noncompliance

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		The other two were considered allergies, and the minutes indicated that pharmacy was awaiting orders to add this to the allergy history of the individual. This had not occurred by the time of the January P&T Committee meeting. The 4/3/13 P&T Committee meeting indicated there were no adverse drug reactions reported during the quarter from January through March 2013. It was noted that a committee would be formed to create a corrective action plan to address lack of reporting of ADRs. Minutes of this subcommittee were to have been available at the P&T Committee meeting, but the attached was not included in the packet submitted for review. The Facility remained out of compliance with this provision. Not all relevant staff had been trained on recognizing and reporting potential ADRs, including new physicians and direct support professionals. As the Facility recognized, this likely was resulting in underreporting. In addition, ADR forms were not completed fully.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The drug utilization evaluations planned for the calendar year 2013 were submitted. This plan was considered a draft, as P&T Committee review and finalization were pending. The plan included the following DUE studies: ▪ 1st Quarter 2013 - January: Vitamin D; ▪ 1st Quarter 2013 - January: Lactinex usage review; ▪ 1st Quarter 2013 - February: Depakote – comparison of dosage forms; ▪ 2nd Quarter 2013 - June: Dificid (fidaxamicin); and ▪ 4th Quarter 2013 - October: Antibiotic use for UTIs. Additionally, a DUE follow-up calendar was submitted with the following schedule: ▪ 1st Quarter 2013 - February: proton pump inhibitors; ▪ 2nd Quarter 2013 - June: Depakote – seizure activity after change in dosage form; ▪ 3rd Quarter 2013 - August: Vitamin D – guideline adherence; and ▪ 4th Quarter 2013 - December: Latuda – follow-up on change in Hgb A1C and weight after initiation. During the prior six months, two DUE studies were completed: ▪ A DUE concerning Lurasidone (date of review 10/22/12) was presented at the 12/12/12 P&T Committee meeting. Duration of therapy, indications for use, drug safety, and drug effectiveness were reviewed in 22 individuals that had been prescribed this medication. There were minimal metabolic effects found. Ten had been taken off the medication, nine of which were due to lack of efficacy. For one individual, the medication was used for an emergency administration for stabilization. Two individuals had moved to the community. ▪ Benzodiazepine use (the review was undated) was also completed as a follow-up	Substantial Compliance

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		study to a prior DUE. This reviewed the long-term use of benzodiazepines and reviewed the original sample of 33 individuals. Four of these individuals no longer resided at CCSSLC. For nine (27%) individuals, the benzodiazepine was discontinued. The DUE for benzodiazepines had a significant impact of reduction of benzodiazepine use at CCSSLC. The January 30, 2013 P&T Committee meeting minutes documented that there was a presentation of a DUE concerning Vitamin D use (the review was undated), and laboratory guidelines. An additional DUE was completed concerning Lactinex use in September and October 2012. Of the 1650 doses prescribed, for one Residential Unit, 468 (28%) doses were returned to pharmacy for an unknown reason. Biogaia was recommended as an alternative at the conclusion of the study, because it was administered only once per day. In a follow-up completed in December 2012, only 274 doses of Lactinex had been dispensed. Two hundred doses of Biogaia had been dispensed, indicating the PCPs were changing the orders for this medication in response to the DUE. Both the Lactinex and Biogaia studies were undated. It is recommended that the date of completion be included in the final documents. The Facility remained in substantial compliance with this provision.	
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.	<u>Policies and Procedures regarding Medication Variances</u> The Facility documented that there had been no changes in policies or procedures concerning medication variance. However, there was an untitled policy approved 1/31/13, implemented 1/31/13, that underwent further revision 2/12/13, with the description: "This policy addresses proper placement of drugs in medication rooms and medication carts." The status of the revision was not further clarified. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Committee meetings. The following describes some of the findings of this committee. The Medication Committee meeting minutes of 11/29/12 documented 18 true errors in September 2012 and 212 Medication Administration (MAR) blanks. For October 2012, there were 14 true errors reported and 357 MAR blanks. The Medication Area Inspection Facility Compliance report for October 2012 indicated need for improvement in many areas, including the following areas according to the monitoring tool indicators: ▪ A working thermometer is present in each refrigerator containing medications	Noncompliance

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		(92% compliance). ▪ Refrigerator temperature is between 36 and 46 degrees. Log is up-to-date (85% compliance). ▪ Medication refrigerators contain only drugs, with appropriate warning signs on refrigerator (92%). ▪ Refrigerators are clean and free of excessive frost (92%). ▪ Medication room and medication cart is locked (92%). ▪ Opened containers are labeled with date opened and initialed (77%). ▪ Cabinets and shelves are clean (92%). ▪ Medication room floor is clean (85%). ▪ Sink, soap, and paper towels are readily available (92%). ▪ Medication cart is clean and free of medication residue and dust (92%). ▪ No out-of-date items in medication room (85%). ▪ Medication cart: internal and external medications stored separately (85%). ▪ Medication cart: open containers are labeled with date opened and initialed (92%). ▪ Refrigerator freezer temperatures are recorded daily (54%). ▪ Glucometer controls checked per policy (58%). The minutes of the 1/3/13 Medication Committee meeting documented 13 true errors in November 2012. There were 119 MAR blanks. The medication Area Inspection Record Compliance data for November 2012 continued to indicate concerns. The 1/22/13 Medication Committee meeting minutes reflected the new pharmacy process in counting medication errors. There were 1089 true errors in December 2012. Nine hundred thirty four (86%) were the returned un-reconciled excess shortage process and MAR blank reconciliation, and 130 (12%) were omissions determined by medication review at the time of QDRR completion. One hundred ten of the 934 (12%) were MAR blanks. Due to the high number of un-reconciled medications, nursing administration required the residences with the highest rate of un-reconciled medications to complete medication counts at each shift change. Additional audits of medication rooms were assigned to administrative RNs. The 3/28/13 Medication Committee meeting minutes indicated that there were 702 true errors in January 2013. The chart entitled "January 2013 All Data" documented there were seven unknown shortages, and 662 unknown excess medications. Excess orders discontinued or orders changed created 330 medication variances. Excess furlough, discharge, and school medications created 108 medication variances. Excess medications based on a charted order caused 189 medication variances. Excess resident refused doses contributed to 580 medication variances. The total variance count for the	

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		month of January 2013 was 2858. For February 2013, there were 156 un-reconciled variances. One hundred seventeen of these were excesses and 39 were shortages. The MARs had 139 blanks. The chart entitled "February 2013 All Data" totaled 2510 medication variances (including 813 excess order discontinued/orders changed, 572 due to excess furlough/discharge/school medications, and 803 due to excess resident refused doses). The chart entitled "Medication Errors 12 Month Summary" reported data from September 2012 through February 2013. Pharmacy errors ranged from zero per month to 10 per month. Un-reconciled errors in December 2012 through February 2013 declined from 933 in December to 103 in February 2013. Omissions (MAR blanks) totaled 212 in September 2012, dropped to 110 in December and were 139 in February 2013. Although the many categories and the details provided were difficult to interpret, it appeared there was a rapid decline in the un-reconciled errors, as other reasons for excess medications became more clearly defined and reported. The new reporting and reconciling system put into place by the Pharmacy Department had allowed for improved accuracy in determining the cause of returned medications. The Clinical Pharmacist role in reviewing refill orders for liquid medications during QDRR review had also improved tracking of medication administration at the Facility. A number of other Pharmacy initiatives listed later in this section had contributed to improved accountability and accuracy of data for medication variances. Also submitted were Medication Error Review Committee minutes, which included the RN Case managers and Nurse Educators. This committee reviewed the details of the medication errors and follow-up with the nurses associated with the medication errors. The Medication Error Review Committee meeting minutes were submitted for 10/15/12, 11/29/12, 1/3/13, and 1/22/13. The December 2012 P&T Committee meeting minutes reported that 78 administration medication errors had occurred in September and October 2012. Error types included wrong time, wrong dose, and wrong number of medications dispensed. The January 30, 2013 P&T Committee meeting minutes reflected the results of the new cart exchange reconciliation procedure and provided similar information concerning medication errors as the Medication Committee. For December 2012, 934 non-reconciled variances had occurred. There were also 130 omissions of medication, which were found by reviewing the dispensing logs for oral liquids during the QDRR review. The April 3, 2013 P&T Committee meeting provided summary information concerning	

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		medication variances that was already described in the Medication Committee minutes. Medication Error Reports Copies of 10 recent medication error forms were submitted for review. These medication errors occurred from 1/2/13 through 1/24/13. One individual had two reports of medication errors from separate days during this time interval. The medications were for Divalproex and Zyprexa. Other medication errors during this time period included Clonazepam, Seroquel, Vimpat, Miralax, Lorazepam, and Xopenex. There were zero Class A medication errors, zero Class B medication errors, 10 Class C medication errors, and zero Class D medication errors. There was one medication error, which was misclassified. The error was reported as an omission of a medication and classified as Category B. By definition, this was a Category C error. Each report had a follow-up response, although there was no concise action plan noted on these documents (e.g., who would follow up, when that would occur, with what frequency, or other demonstration of how the Facility would increase monitoring/training to ensure this will not occur again, etc.). It is recommended that Pharmacy review the medication error reports to determine accuracy of categorization of errors, and to assist the Nursing Department in developing measurable steps as part of the corrective actions taken for these medication errors. Pharmacy Review of Categorization of Errors Additionally, the Pharmacy Department was not actively verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. Medication Observation Monitoring Copies of 24 completed medication administration observation forms were submitted from December 2012. For one observation, the nurse failed. Scores for the other 23 ranged from 95 to 100. Copies of 25 medication administration observation completed forms were submitted from January 2013. For one observation, the nurse failed an essential component. Scores for the other 24 ranged from 89 to 100. The numbers of the medication administration observations submitted did not match the numbers recorded in the minutes of the Medication Committee meeting minutes, although they closely approximated the January and February 2013 total number of medication observations recorded in the minutes. Pharmacy activities to reduce medication variance Interventions/steps taken by Pharmacy to reduce the numbers of medication errors	

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		included the following: ▪ For errors originating in the Pharmacy Department: The pharmacy used a coding system for pharmacy variance: o A. Quantity Excess - Pharmacy Miscount; o B. Quantity Short – Pharmacy Miscount; o C. Wrong Medication – Pharmacy Error; o D. Wrong Medication - Order change/discontinued after set delivered; o E. Quantity Short – Medication pulled from new set to replace missing dose; and o F. Quantity Short – Medication missing from unit dose packaging. ▪ For errors originating in the Nursing Department: The pharmacy used a coding system for nursing variance indicating categories and subcategories of causes: o Quantity Short (lost medication room key, dose wasted/lost/spit out/etc., unknown); o Quantity Excess (unknown, order discontinued/order changed/etc., furlough/school meds/etc., medication held based on a charted order, individual refused dose); and o Documented medication error (quantity excess - documented medication error, quantity short - documented medication error). The Pharmacy Department defined a step-by-step process. A nine-step process for medication excess and a six-step process for medication shortage were completed. One pharmacy technician was dedicated to the data collection, form completion, and analysis of the results of the process. Following the collection and coding process, a Medication Reconciliation Report was generated by the Pharmacy Department. Information in this report included all the reasons for a medication variance, by week, and the number of occurrences per week. Similar data was summarized per month. Residence information was also available. ▪ For errors originating with the PCPs: o There did not appear to be a code system for PCP errors. It is recommended that this be added to the coding system for medication variance. Based on the development and implementation of the Medication Reconciliation Report system, the Pharmacy took interventions/steps to determine the cause and reduce the rate of return of unknown excess medications. These additional steps were outlined in a document submitted entitled "Medication Variance Identification and Review." These action steps included: ▪ The Pharmacy Department added the date dispensed to the labels of medication, such as topicals, inhalants, ophthalmics, otics, and other bulk refills (i.e., not unit	

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		dose dispensed medication); ▪ The Pharmacy Department initiated medication room inspections weekly on each residence (previously completed monthly); ▪ For residences with large volumes of medication, a twice weekly medication cart fill was initiated; ▪ The Nursing Department initiated cart fill medication counts at shift change on selected residences; and ▪ Medications were to be delivered to the residences throughout the day so nurses could stay in their medication rooms and complete activities with less interruption. ▪ Based on the Clinical Pharmacist findings that refills of liquid medication forms were not requested in a timely manner, the following steps were taken: 1) a medication error report was completed for each event, and was tracked by nursing; 2) a DUE was initiated to allow lower dosing and greater use of crushable tablets versus liquids; and 3) selected liquids were changed to unit dose packaging to remove the need for nursing to request refills; ▪ The Pharmacy ensured a process in which no medication orders remained at the end of the day, but all doses were delivered; ▪ A cart fill exchange was checked at time of delivery by the nurse and pharmacy personnel while in the medication room; ▪ Pharmacy delivered narcotics and ensured a narcotic count in the medication room with the nurse at the time of arrival of the narcotic; ▪ Floor stock was reduced and adapted to the requirements of each residence. This assisted in streamlining the weekly medication room checks and medication pass system. Some orders were moved from floor stock to the medication cart fill process. Reducing floor stock maximized accountability of every medication utilized. The Pharmacy Department listed 30 medications, which were removed from floor stock, and would be dispensed by medication cart. ▪ The Pharmacy Department provided containers to assist in keeping internal and external medications separate, both in the cart and in the medication room; ▪ Additional containers were provided for medications that needed to remain upright; ▪ The Pharmacy Department provided a list of medication storage requirements concerning medication expiration dates and indicating the medications requiring documentation of the date the package/container was opened; ▪ The Pharmacy Department identified a concern from nursing in which medication was difficult to administer (e.g., Depakote Sprinkles via g tubes). Through the efforts of the Clinical Pharmacist working with the PCPs, the form of medication was able to be changed and new orders written. At the time of the	

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		document providing this information, the number of Depakote Sprinkle capsules ordered per day had been reduced from 267 to 24. The Pharmacy Department provided an in-service to nursing staff on all shifts concerning medication variance. The training roster was attached. Training occurred from 3/15/13 through 3/19/13. The roster included signatures from 99 nurses. These numerous endeavors on the part of the Pharmacy Department represented an aggressive approach toward medication accountability. It appears the number of un-reconciled medications has begun to drop. Sustaining the drop will be a challenge. The number of omissions of medications by nursing appeared to have plateaued. Although the Pharmacy Department had made significant progress in attempting to address the medication variance issues, these efforts were in the initial phases, and more work was needed to ensure the efforts undertaken were effective in resolving the significant medication variance issues. The Facility remained out of compliance with this provision.	

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

1. All patient intervention notes should include the medication and dosage, as well as the concern, with documentation of the content of the communication to the PCP and the response from the PCP. (Section N.1)
2. Each patient intervention note should be categorized. (Section N.1)
3. The Pharmacy Department should choose a small selection of categories to cover most new order communications. (Section N.1)
4. The pharmacy section of the chemical restraint form should include the name of the medication, dosage, and route. This document should be corrected for medication omissions and errors. (Section N.3)
5. A system of in-service training should be implemented with new PCPs as well as direct support professionals with regard to the ADR policy and procedures. (Section N.6)
6. The Pharmacy Department should review the medication error reports to determine accuracy of categorization of errors, and to assist the Nursing Department in developing measurable steps as part of the corrective actions taken for these medication errors. (Section N.8)
7. There did not appear to be a medication variance code system for PCP errors. It is recommended that this be added to the coding system for medication variance. (Section N.8)

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 for 15 individuals in Sample #1 (i.e., Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99), including: Preferences and Strengths Inventory, List of assessments/reports needed for the annual ISP meeting, List of IDT members to attend the annual ISP meeting, Pre-ISP Preparation Meeting documentation, Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post-Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for individuals in Sample #2 (i.e., Individual #183, Individual #153, Individual #155, Individual #357, Individual #144, and Individual #270) on the Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months; as well as a sample of four individuals who had been discharged by the PNMT: Individual #58, Individual #278, Individual #311, and Individual #247) including: Preferences and Strengths Inventory, List of assessments/reports needed for the annual ISP meeting, List of IDT members to attend the annual ISP meeting, Pre-ISP Preparation Meeting documentation PNMT assessment, PNMT action plan and supporting documentation, HOBE assessment, APEN assessment/tool, annual ISP and

	ISPAs for past year, IRRF prior to referral to PNMT, IRRF completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, PNMP and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post-Hospitalization assessment, Nursing Care Plan/Integrated Care Plan, documentation of staff successfully completing PNM foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o The following documents for individuals in Sample O.3 (i.e., Individual #232, Individual #126, Individual #260, Individual #340, Individual #110, Individual #299, Individual #327, Individual #127, Individual #134, and Individual #68) including: Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment/tool, Speech Language Pathology (SLP) comprehensive assessment, SLP assessment of status, SLP update, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT and corresponding caseload; o List of all individuals the PNMT assessed and the date of assessment; o List of all individuals the PNMT discharged; o Physical Nutritional Management Policy and Procedure; o List of continuing education sessions participated in by PNMT members; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff; o Minutes and documentation of attendance for PNMT meetings; o List of changes in PNMT evaluation form;

	o Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels; o List of individuals with PNM needs; o List of individuals without PNM needs; o Wheelchair/Mobility/Assistive Equipment Work Orders; o Completed PNMPs and Dining Plans; o List of tools PNMP Coordinators use to monitor staff compliance; o List of individuals for whom PNM monitoring tools were completed during last quarter; o Tools utilized for validation of competency of staff responsible for PNM monitoring; o Inter-Rater Reliability Scores; o Dining Plan (template) with changes; o PNM and PNMT-related database reports, and spreadsheets generated by Facility; o List of individuals on modified/thickened liquids; o List of individuals who require mealtime assistance; o List of individuals who receive nutrition through non-oral methods; o List of individuals whose diets have been downgraded or changed to a modified texture or consistency; o List of individuals with Body Mass Index (BMI) equal to or greater than 30; o List of individuals with BMI equal to or less than 20; o List of individuals who have had an unplanned weight loss of 10% or greater over a six-month period; o List of individuals who have had a choking incident during the past six months; o List of individuals who have had an aspiration and/or pneumonia incident during the past six months; o List of individuals who have had a fall during the past six months; o List of individuals who have had a decubitus/pressure ulcer during the past six months; o List of individuals who have experienced a fracture during the past six months; o List of individuals who have had a fecal impaction during the past six months; o List of individuals who are non-ambulatory or require assisted ambulation; o List of individuals with poor oral hygiene; o List of individuals who received a feeding tube since the last review; o List of individuals who are at risk of receiving a feeding tube; o List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year; o Schedule of meals by residence; o Schedule of all PNM-related meetings occurring during the week of the onsite review; o Curricula on PNM used to train new staff responsible for directly assisting individuals; o Agenda and curriculum for competency-based, annual refresher training related to PNM; o List of completed PNMT Nursing Post Hospitalization Assessments/Evaluations; o The following documents for Individual #250 and Individual #2 on the PNMT caseload were submitted prior to the onsite review: PNMT Minutes, PNMT Assessments, Integrated Risk Rating forms, APEN Assessments, HOBE Assessments, PNMT Action Plans, Staff

	Competency-based Check-offs, PNMT Monitoring Forms, PNMPs, PNMT Nursing Post Hospitalization Assessments, and ISPA meeting documentation related to integration of PNMT assessments and Action Plans; o Quality Assurance/Quality Improvement meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department; o Minutes from the HT Department meetings for the past six months; o External PNM consultant reports since the Monitoring Team's last review; o Changes to Physical Nutritional Management Plan templates since the Monitoring Team's last review; o Raw data for Section O monitoring; o QA/QI Quarterly Section Review for Section O for last two quarters; o From October 2012 to March 2013, number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in new employee orientation over last six months (N); o From October 2012 to March 2013, number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); o From October 2012 to March 2013, number of current staff who have completed annual refresher training (n), over number of staff required to complete annual refresher training (N); o At Risk Rating List with upgrades and downgrades; o Short version of PNMT Report to ICS for February and March 2013; o Curriculum vitas for PNMT core members; o License numbers of PNMT core members; o List of individuals referred to PNMT in the past six months with referral forms; o Copy of PNMT referral form; o List of approved trainers for NEO and annual refresher PNM foundational training; o List of approved trainers for PNM individual-specific training (i.e., non-foundational); and o Total number of dining room monitors and total number of dining room monitors who have completed competency based training and performance check-offs. ▪ **Interviews with:** o Dr. Angela Roberts, Director of Habilitation Therapy; o Mary Wilcox, PNMT Coordinator, RN and Core Member; o Rosie Cortez, PNMT OT, Core Member; o Maria I. Garcia, PNMT PT, Core Member; o Cynthia Spurgat, PNMT RD, Core Member; o Melissa Grothe, PNMT SLP, Core Member; and o Dana Verhey, Program Compliance Monitor, QA Department. ▪ **Observations of:** o Individuals in the Infirmary; residences and dining rooms, including Coral Sea, Pacific, and Atlantic; and o PNMT Core and Follow-up meetings, on 4/2/13.

	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 3/18/13. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT, Section O Lead, and Program Compliance Monitor: o The monitoring/audit tool the Facility used to conduct its self-assessment included: the State Section O Monitoring Tool and various Facility-developed audit tools to assess compliance with indicators presented in the Monitoring Team's reports. The Director of HT stated that the current Monitoring Tool did not accurately assess the Facility's current compliance status in each of the sections. The Director of HT wanted to revise the monitoring tool to incorporate the indicators/metrics from the Monitoring Team's report that more accurately assessed the status of compliance within each of the sections. o The Monitoring Team agreed that the current unrevised Monitoring Tool for Section O did not include adequate indicators to allow the Facility to determine the current state of compliance with Section O. However, the data presented in the self-assessment reflected the completion of activities/audits completed outside of the scope of the Monitoring Tool for Section O. These audits represented a positive move forward in monitoring compliance with Section O. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. The development of the template for the presentation of data also was a very promising step forward in aligning the items to be monitored with the Monitoring Team's indicators/metrics. o The monitoring tool did include adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and the PCM continued to revise the monitoring tool guidelines. o The following staff/positions were responsible for completing the audit tool: The Director of HT and the PCM. o Adequate inter-rater reliability had been established between the Director of HT and the PCM. ▪ The Facility used some other relevant data sources, including, for example, a PNMT assessment audit tool, PNMP audit tool, and the HT Department database. ▪ The Facility presented some of the data in a meaningful/useful way, but in other instances work

	was needed. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with none of the subsections of Section O. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The Facility PNMT had five core members [i.e., Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist (OT), Registered Dietician (RD), and a Speech Language Pathologist (SLP)]. The Facility PNMT reported accessing various medical consultants. However, a review of PNMT documentation did not support routine participation by medical consultants. The Facility had PNM policies. However, these policies did not contain all of the necessary components. The PNMT Coordinator/RN presented a PNMT report on Fridays at the Integrated Clinical Services Team meeting, which included an update on individuals on the PNMT caseload and presentation of the status of identified systemic issues. However, the Facility should support an enhanced sense of urgency in resolving systemic issues. Some individuals who met the Facility PNMT referral criteria had not been referred to the PNMT. A review of individuals' PNMT assessments and IHCPs identified multiple missing essential components. The PNMT had developed a discharge summary template. However, additional work needed to be done. Documentation supported a meeting between the PNMT and the IDT, but this meeting was not documented as an ISPA meeting to support integration of changes to individuals' supports and services. Additional work needed to be done to ensure PNMP content included the necessary components. The Monitoring Team, members of the PNMT, and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMP and dining plan strategies. These observations revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk. The Facility had made significant progress in completing foundational PNM training, which included the successful completion of 22 competency performance check-offs for new employees and current staff. Five individuals required individual-specific PNMP strategies. The Facility had initiated individual-specific training. However, a review of staff observation sheets for one individual over a period of 15 days indicated that a significant number of this individual's staff had not been trained.

	The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties, or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. Monthly progress notes were not completed to report on the effectiveness of individuals' supports and services, individuals' PNMPs and aspiration trigger data sheets did not have individual-specific triggers identified, and aspiration pneumonia trigger data sheets were not completed as required on a daily basis. The HT Department database maintained and updated a list of individuals who received enteral nutrition. However, this process was not captured in Facility policy and/or procedure. Individuals in the sample, who received enteral nutrition, were reviewed by the IDT. However, the annual assessment did not include the necessary components. Individuals who were transitioning to oral eating did not have a formal plan.

#	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,	As noted above with regard to the documents reviewed section, four samples were selected for the review of Section O. These included: ▪ **Sample O.1** consisted of a non-random sample of 15 individuals, who were chosen from a list provided by the Facility, of individuals identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis, require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These 15 individuals were: Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99; ▪ **Sample O.2** consisted of 100 percent of the individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included six individuals: Individual #183, Individual #153, Individual #155, Individual #357, Individual #144, and Individual #270. In addition, a sample of four individuals who had been discharged by the PNMT was selected: Individual #58, Individual #278, Individual #311, and Individual #247. This did not include any duplication from Sample O.1. ▪ **Sample O.3** consisted of 10 individuals at CCSSLC who received enteral nutrition. These 10 individuals were: Individual #232, Individual #126, Individual #260, Individual #340, Individual #110, Individual #299, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	#327, Individual #127, Individual #134, and Individual #68. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 13 individuals (i.e., Individual #228, Individual #67, Individual #329, Individual #25, Individual #19, Individual #379, Individual #207, Individual #153, Individual #155, Individual #142, Individual #19, Individual #3, and Individual #135) observed in residences and day programs throughout the 24-hour day. This included random individual-specific observations as well as 20 percent of the individuals in Sample O.2. Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, 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. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the Settlement Agreement. In addition, Section O.1 specifically requires that: "The 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 PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team." The status of these requirements is discussed with regard to Section O.3. **PNM Policy and Role of the PNMT** The Facility had the following policies: ▪ Policy O.2: Physical and Nutritional Management Participating in PNMT Meetings, revised and implemented on 11/13/12; ▪ Policy O.2.1: Physical and Nutritional Management Roles of PNMT Members, revised on 5/31/11, but there was no date of implementation; and ▪ State Policy 012.3: Physical Nutritional Management. A review of these policies found the Facility did not have a comprehensive PNM policy (Note: This metric addresses the presence of a Facility PNM policy. The implementation of these elements is addressed in Section O.2 through O.8). The Facility's policies did include some of the necessary components, but not others. Those components that it did not include were: ▪ Requirements for continuing education for PNMT members. The policy should address the specific requirements, if any, for PNMT members to ensure they	

#	Provision	Assessment of Status	Compliance
		have ongoing training related to their duties as a PNMT member; ▪ Discharge criteria from the PNMT; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, and actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitoring, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The PNMT/Habilitation Therapies' policies might reference this system, but it should be based on QA/QI policies that define this overall system. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, and QA/QI meeting): o A process for identifying who will be responsible for resolution of the	

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		systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate, to measure the resolution of systemic issues. **Core PNMT Membership** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate disciplines as defined in the Settlement Agreement. PNMT members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, and a Speech Language Pathologist. **Consultation with Medical Providers and IDT Members** For none of the six individuals in Sample O.2 (0%), evidence was provided of routine participation of medical providers in meetings, review of assessments, and other needed activities. The PNMT should always consult with the individual's medical provider during the completion of the PNMT assessment and ongoing follow-up, because they provide supports to high-risk individuals with significant health, physical, and nutritional concerns. The Team should seek additional expertise as identified by the PNMT assessment. Medical providers were not in attendance during PNMT core and/or follow-up meetings. The Facility provided a list of medical consultants used by the PNMT (i.e., psychiatry, neurology, ear nose and throat, nephrology, pulmonology, ophthalmologist, orthopedics, physical therapy gait analysis, orthotics, hematology, and gastroenterologist). However, PNMT meeting minutes, attendance rosters, PNMT assessments, and other documentation did not indicate that these medical consultants participated. For six of six individuals in Sample O.2 (100%), evidence was provided of routine participation of other IDT members in meetings, review of assessments and other needed activities. **Qualifications of PNMT Members** Five of five PNMT members (100%) were licensed to practice in the state of Texas. Five of five PNMT core members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. PNMT members had specialized training demonstrating competence in working with individuals with complex physical and nutritional management needs. Specialized training is defined as graduate education or continuing education content that is relevant to enhancing the provision of supports to individuals with identified PNM	

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		concerns. **Continuing Education** Four of five PNMT staff (80%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. The Registered Dietician had not. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Dementia Care (8/14/12), Annual Habilitation Therapies Conference (9/19/12 to 9/21/12), and NPO Recommendations from the MBSS [Modified Barium Swallow Study] for Adults (1/26/13); ▪ SLP attended: Autism, Asperger's Sensory ADHD Seminar (7/18/12), EBP [Evidence-Based Practice] for AAC Evaluations: Building the Meaning Behind the Acronyms (8/1/12 to 8/2/12), Dementia Care (8/14/12), Annual Habilitation Therapies Conference (9/19/12 to 9/21/12), Practical Activities for Milestone Development 11/8/12), and NPO Recommendations from the MBSS [Modified Barium Swallow Study] for Adults (1/26/13); ▪ OT attended: Dementia Care (8/14/12), Annual Habilitation Therapies Conference (9/19-21/12), Texas Occupational Therapy Association Conference (11/2/12 to 11/4/12), and NPO Recommendations from the MBSS [Modified Barium Swallow Study] for Adults (1/26/13); ▪ RD attended: NPO Recommendations from the MBSS [Modified Barium Swallow Study] for Adults (1/26/13); ▪ RN attended: Medication Administration for Nurses (9/19/12), Annual Habilitation Therapies Conference (9/19/12 to 9/21/12), and NPO Recommendations from the MBSS [Modified Barium Swallow Study] for Adults (1/26/13) **PNMT Meetings** From September 2012 to February 2013, the PNMT had met 25 of the 26 (96%) weeks. The team sometimes met more than once a week. Attendance by core PNMT members for 40 meetings conducted during the time frame from September 4, 2012 to February 26, 2013 was: ▪ RN/Chairperson/Coordinator: 95% attendance by core member, 2% for back-up member, and 97% overall; ▪ RD: 90% attendance by core member, 2% for back-up member, and 92% overall; ▪ PT: 82% attendance by core member, 5% for back-up member, and 87% overall; ▪ OT: 98% attendance by core member, 0% for back-up member, and 98% overall; and ▪ SLP: 98% attendance by core member, 0% for back-up member, and 98% overall.	

#	Provision	Assessment of Status	Compliance
		None of the 40 (0%) PNMT meeting minutes documentation (September 2012 to February 2013) consistently included: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. For example: ▪ Individuals were referred to the PNMT, but were not placed on the active caseload. These individuals were referred back to the IDTs with recommendations developed by the PNMT. The PNMT meeting minutes did not indicate these individuals had been followed-up to ascertain if these recommendations had been implemented (i.e., Individual #260, Individual #244, Individual #340, Individual #89, Individual #194, Individual #128, Individual #327, Individual #321, Individual #301, Individual #350, Individual #301, Individual #127, Individual #267, Individual #245, and Individual #156). ▪ PNMT meeting minutes did not consistently report on the status of individuals' clinical health indicators, to assess whether individuals were better or worse, and to analyze the efficacy of their interventions. ▪ Multiple PNMT recommendations/actions had not been implemented in a timely manner, which was indicated in multiple individuals' follow-up meeting minutes. For example, Individual #273's PNMT Follow-Up Meeting on 9/4/12 indicated his PNMP recommendation #1 was to "update PNMP, IRR, APEN, Integrated daily schedule with new recommendations and action plans" and the due date was 7/17/12. However, this recommendation was "pending." This recommendation should have been implemented with a sense of urgency. This problem was evident for all individuals within the sample. ▪ The status of an individual's outcomes and/or progress toward established goals was difficult to track and/or was not present in meeting minutes. The Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. However, some positive interventions had been developed which included: ▪ Each week at the Integrated Clinical Services Team meeting, the PNMT Coordinator/RN presented an update on individuals on the PNMT caseload and status of systemic issues; ▪ Corrective action plans had been developed to address systemic issues of individuals not receiving their prescribed enteral feedings, and environmental issues with feeding equipment and individuals' residences. However, the following concerns were noted: ▪ Corrective action plans initiated in July 2012 for systemic issues (i.e., tracking of weights, receiving prescribed enteral feedings, and environment issues with equipment and residences) had not been fully implemented;	

#	Provision	Assessment of Status	Compliance
		▪ Review of Short Version of PNMT Reports to ICST on Fridays from 2/1/13 to 3/29/13 indicated that systemic issues continued to be raised without resolution and/or monitoring not being conducted to assess the efficacy of proposed resolutions; ▪ The PNMT follow-up meeting minutes on 9/4/12 indicated: "most of the clients we have had concerns about weight are gaining weight and we are starting to get accurate weights." Subsequent meeting minutes continued to report on unresolved reporting of weights. In addition, the Monitoring Team observed a PNMT follow-up meeting and an annual ISP meeting during the onsite review which indicated this issue had not been resolved; and ▪ The Facility PNM policies did not reference the QA/QI process for resolution of systemic issues. In summary, at the time of the review, the Facility's PNMT had the required core members as outlined in the Settlement Agreement. However, medical consultation with the PNMT was not evident. Progress had been made in identifying and addressing systemic issues related to the provision of PNM supports and services. However, the systemic issues continued to not be resolved. The PNMT policy should reference the Facility process for resolution of systemic issues. The expectations and pathways for this process should be formalized in Facility policy and procedure. The Facility remained out of compliance with this provision.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having	**<u>Identification of PNM Risk</u>** Twenty-one of 21 (100%) individuals in Sample O.1 and O.2 who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility did not have a sustainable system to maintain and update lists of individuals who require positioning assistance associated with swallowing activities, who have difficulty swallowing, or who are at risk of choking or aspiration The Facility did have a sustainable system to maintain and update lists of individuals who could not feed himself or herself. As discussed with regard to Section I, although improvements were seen with regard to the identification of risk levels as part of the Integrated Risk Rating process, concerns still existed with regard to the completeness of the data teams used. In addition, teams did not consistently use the risk guidelines when making risk determinations, or provide justification for veering from the guidelines.	Noncompliance

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	physical and nutritional management problems to identify the causes of such problems.	**Physical and Nutritional Management Team Referral Process** Five of eleven individuals (45%) (i.e., Individual #260, Individual #340, Individual #327, Individual #350, and Individual #245) in Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. Four individuals (i.e., Individual #218, Individual #251, Individual #110, and Individual #99) in the sample did not meet the Facility PNMT referral criteria. None of the 11 (0%) individual records reviewed indicated that when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. For the five individuals who were referred to the PNMT as noted above, documentation did not reveal that a referral had been made within five working days of an ISPA meeting. As stated above, six of these 11 individuals had not been referred to the PNMT although they met the Facility PNMT referral criteria. These timeframes should be followed, but actions that are identified earlier or require more expedient implementation should be implemented as they are identified. One of one (100%) individual (i.e., Individual #327) who received a feeding tube (not on an emergency basis) since the last review had been referred to the PNMT prior to the placement of the tube. Based on Facility report, no individual had received an emergency feeding tube placement since the last review. However, if any had, then the Monitoring Team would have assessed whether they had been referred to the PNMT after the emergency feeding tube placement. **PNMT Assessment** Two of six (33%) PNMT assessments (i.e., Individual #155 and Individual #357) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Two of six (33%) PNMT assessments (i.e., Individual #153 and Individual #155) were completed in no less than 30 days of the date initiated, or no more than 45 days in extenuating circumstances (i.e., critical diagnostics requiring outside appointments, hospitalization, etc. with clearly stated rationale). These timeframes should be followed, but actions that are identified earlier or require more expedient implementation should be implemented as they are identified. Based on review of individuals' records, the comprehensiveness of the PNMT assessment components were as follows: ▪ Three of six (50%) (i.e., Individual #153, Individual #357, and Individual #144)	

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		contained date of referral by the IDT; ▪ Three of six (50%) (i.e., Individual # 357, Individual #144, and Individual #270) contained the date the assessment was initiated; ▪ Two of six (33%) (i.e., Individual #155 and Individual #357) contained evidence of review and analysis of the individual's medical history; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) identified the individuals' current risk rating(s), including the current rationale. The PNMT had reviewed the risk ratings the IDT assigned; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ None of six (0%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained assessment of current physical status; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained assessment of musculoskeletal status; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained evaluation of motor skills; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained evaluation of skin integrity; ▪ None of six (0%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Two of six (33%) (i.e., Individual #155 and Individual #357) contained evaluation of current adaptive equipment; ▪ None of six (0%) contained nutritional assessment, including, but not limited to, history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ None of six (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ None of four (0%) identified residual thresholds, if enterally nourished. Individual #153 and Individual #357 ate orally; ▪ One of six (17%) (i.e., Individual #357) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained respiratory status; ▪ None of six (0%) contained evidence of review/analysis of lab work; ▪ None of six (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages,	

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		administration times, and side effects; ▪ One of six (17%) (i.e., Individual #357) contained discussion as to whether existing supports were effective or appropriate; ▪ Two of six (33%) (i.e., Individual #155 and Individual #357) contained oral hygiene status; ▪ None of six (0%) contained evidence of observation of the individual's supports at their home and day/work programs; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) contained evidence that the PNMT conducted hands-on assessment; ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #357) identified the potential causes of the individual's physical and nutritional management problems; ▪ None of six (0%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; ▪ None of six (0%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of six (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of six (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ None of six (0%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and ▪ Three of six (50%) (i.e., Individual #153, Individual #155, and Individual #144) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ None of the six (0%) contained signatures with dates. Individuals should, at a minimum, be provided with a comprehensive PNMT initial assessment upon referral that covers all the components listed above. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For none of the six (0%) individuals, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs and IHCPs. Plans resulting from PNMT recommendations included the following components: ▪ In none of the six (0%) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. The	

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		individuals' plans were not integrated into IHCPs. The IHCPs should have included specific and measurable steps that incorporated relevant clinical interventions and addressed recommendations discussed in the individual's PNMT assessment to minimize the individual's identified PNM problems. The PNMT action plan (i.e., integrated into IHCP) should have included interventions across the 24-hour day, seven days a week to be implemented by PNMT members, nursing staff, direct support professionals and other staff as identified. There should be interventions developed and implemented within relevant risk areas to minimize these risk conditions. Preventative interventions should address the etiology of the problem, and be written in measurable terms. ▪ In none of the six (0%) individuals for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. Individuals had HOBE assessments, however, these recommendations from these plans were not consistently integrated into IHCPs. ▪ In none of the six (0%) individuals' plans reviewed, there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. The IHCPs did not include appropriate and functional objectives. "Appropriate" is defined as objectives are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of the six (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. A review of PNMT action plans indicated that some of the recommendations were addressed in a timely manner. However, there were recommendations that were not addressed with the necessary sense of urgency. ▪ In none of the six (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the six (0%) individuals' plans reviewed, the plans defined triggers. Some plans identified triggers, however, there were risk areas where triggers were not identified. ▪ In none of the six (0%) individuals' plans reviewed, the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation: ▪ In none of six (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. ▪ In none of the six (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and	

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		a plan for completing the action steps. **Individuals Discharged by the PNMT** Since the last review, the PNMT had developed and implemented a PNMT Discharge Summary template. It included the reason for the referral, risks, analysis, PNMT recommendations completed, and discharge recommendations. A review of four individuals' discharge summaries showed improvement from the last review. However, the discharge summaries were missing key elements as noted below. Review of four individuals' discharge summaries (i.e., Individual #58, Individual #278, Individual #311, and Individual #247) developed by the PNMT found: ▪ None of the four (0%) individuals had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. There was documentation of a joint meeting between the PNMT and IDT, but the meeting was not documented as an ISPA. As a result, it was not clear that the meeting had resulted in changes to the individuals' ISPs, as appropriate. ▪ One of the four (25%) individuals' discharge summary/action plans (i.e., Individual #278) provided objective clinical data to justify the discharge. ▪ None of the four (0%) individuals' ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ Four of the four (100%) individuals' action plans included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the PNMT should ensure assessments, IHCPs, and discharge summaries include the essential components discussed within this section. The Facility's PNMT audit tools should assess the quality of PNMT work products and incorporate the essential components of assessments and plans. The Facility remained out of compliance with this provision.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding	**Identification of Individuals Requiring a PNMP** None of the 15 (0%) individuals' annual ISPs in Sample O.1 noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. Individuals' annual ISP meetings lacked attendance by appropriate disciplines and/or there was not adequate justification in the ISP Preparation meeting documentation to support the attendance of therapists and/or dieticians. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic	Noncompliance

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	and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. In assessing this requirement, the Monitoring Teams reviewed the ISP Preparation Meeting documentation that should have included such documentation, as well as the ISP sign-in sheets. None of 15 (0%) individual's PNMPs for individuals in Sample O.1 were reviewed by the individual's IDT in the annual ISP meeting. Individuals' ISPs would state the PNMP was reviewed, but there was no evidence to address the effectiveness of the PNMP and/or discussion of any updates and/or revisions to an individual's PNMP. This needed to include evidence of review, update/revision, effectiveness, and specified changes required with rationale. **PNMP Format and Content** A review of 21 individuals' PNMPs in Sample O.1 (15 individuals) and O.2 (six individuals) found the following: ▪ PNMPs for 21 of 21 (100%) individuals were current within the last 12 months. ▪ PNMPs for none of 21 (0%) individuals included a list of all high-risk levels, individual triggers, and outcomes. ▪ In 21 of 21 most current PNMPs (100%), there were large and clear photographs with instructions. ▪ Six of 21 (29%) PNMPs (i.e., Individual #232, Individual #218, Individual #340, Individual #67, Individual #299, and Individual #155) listed the adaptive equipment required by the individual with rationale. ▪ In none of 16 (0%) PNMPs for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions were provided. The PNMP reviewed did not include instructions for safe elevation ranges, frequency of re-positioning, and/or non-foundational/individual-specific information. Individual #218, Individual #74, Individual #99, Individual #153, and Individual #144 did not use wheelchairs as their primary mobility. ▪ In none of 16 (0%) PNMPs, positioning was adequately described per the individuals' assessments. A review of individual's OT/PT assessments did not provide a description of alternate positioning, which should include safe elevation ranges, alternate, bedtime, other positioning as indicated, and non-foundational/individual-specific instructions. ▪ In 20 of 21 (95%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. Individual #183's transfer was not adequately described. ▪ In 13 of 21 (62%) PNMPs (i.e., Individual #232, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #74,	

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		Individual #299, Individual #327, Individual #183, Individual #155, Individual #144, and Individual #270), bathing instructions were provided. Instructions included bathing equipment, strategies, independence, and level of staff assistance required. ▪ In three of 21 (14%) PNMPs, (i.e., Individual #218, Individual #67, and Individual #74), toileting-related instructions were provided, including check and change. Instructions should include level of independence, and level of staff assistance required. ▪ In four of 16 (25%) PNMPs, (i.e., Individual #260, Individual #218, Individual #340, and Individual #270) handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. The other five individuals were described as independent. ▪ In 20 of 20 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. Individual #218 did not have a dining plan. ▪ Nineteen of 20 individuals' (95%) Dining Plans were current within the last 12 months**.** Individual #155's dining plan was not current. ▪ Twelve of 21 individuals had feeding tubes with no oral intake (i.e., Individual #232, Individual #126, Individual #260, Individual #340, Individual #110, Individual #299, Individual #327, Individual #350, Individual #245, Individual #182, Individual #155, and Individual #270). None of 12 (0%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In 11 of 20 (55%) PNMPs/dining plans (i.e., Individual #126, Individual#260, Individual #340, Individual #251, Individual #67, Individual #327, Individual #350, Individual #245, Individual #183, Individual #357, and Individual #270), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ In eight of eight (100%) PNMPs/dining plans for individuals who ate orally (i.e., Individual #182, Individual #251, Individual #67, Individual #74, Individual #99, Individual #153, Individual #357, and Individual #144) diet orders for food texture were included. ▪ In eight of eight (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. ▪ In 13 of 20 (65%) PNMPs/dining plans for individuals who ate orally (i.e., Individual #232, Individual #126, Individual #260, Individual #340, Individual #110, Individual #299, Individual #327, Individual #350, Individual #245, Individual #183, Individual #155, Individual #357, and Individual #270), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided.	

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		▪ In six of 21 (29%) PNMPs, (i.e., Individual #218, Individual #340, Individual #350, Individual #245, Individual #153, and Individual #144) medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In none of 21 (0%) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. ▪ Twenty-one of 21 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 11 individuals in Sample O.1 (i.e., 11 of 15 individuals: Individual #232, Individual #182, Individual #126, Individual #340, Individual #251, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99) and six individuals in Sample O.2 (i.e., six of six individuals: Individual #183, Individual #153, Individual #155, Individual #357, Individual #144, and Individual #270) for whom the IDT and PNMT identified changes needed to be made to the PNMP, one of 17 (6%) individuals had ISPA meeting documentation which noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. For individuals for whom the PNMP was revised, there was supporting documentation that none of the 17 (0%) individuals' revised PNMPs had been implemented. The Monitoring Team did not find evidence in ISPA meetings that the revisions were agreed upon and/or discussed the implementation of these PNMP revisions. PNMPs were missing essential components. An ISPA meeting should be convened to present, discuss, and approve PNMP revisions. The Facility remained out of compliance with this provision.	
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	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** Staff did not engage in safe mealtime practices, as indicated by the following: Base on the Monitoring Team's observations, none of the six (0%) individuals' (i.e., Individual #67, Individual #329, Individual #19, Individual #379, Individual #207, and Individual #153) dining plans were implemented as written. Facility therapists acknowledged these concerns during these observations. Based on observations: ▪ None of seven (0%) individuals' positioning plans (i.e., Individual #67, Individual #155, Individual #142, Individual #19, Individual #3, Individual #153, and Individual #135) were implemented as written. ▪ None of three (0%) individuals' pivot transfer plans (i.e., Individual #67,	Noncompliance

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	provoke swallowing difficulties.	Individual #329, and Individual #228) were implemented correctly. ▪ In none of one (0%) observation of medication administration (i.e., Individual #25), the nurse followed procedures in the PNMP. The PNMP provides the foundation for health and safety. These observations the Monitoring Team, PNMT members and Facility therapists completed substantiated that staff were not competent and/or compliant in implementing foundational PNMP strategies. The Monitoring Team was concerned that the staff's failure to implement PNMPs was an overriding issue in the last onsite review, and, unfortunately, continued to be of significant concern during this review. For example, the Monitoring Team and three members of the PNMT (i.e., PNMT Nurse, PNMT SLP and PNMT OT) observed Individual #153. The staff person assigned to him in the Infirmary consistently breached his PNMP. Individual #153 was observed lying flat on his bed although his PNMP stated he was never to lay flat; an unsafe transfer was completed from his bed; the staff person was not positioned correctly during presentation of his meal, and the presentation techniques on his dining plan were not followed. The PNMT members had to intervene throughout the observation. This staff member was engaging in practices that posed an undue risk of harm in implementing his PNMP. The Facility should move forward with a sense of urgency to provide additional support to staff to enhance their competency in the implementation of PNMPs, most importantly, for those individuals at highest risk. In summary, the Facility should place a high priority on staff compliance with individuals' PNMPs. The Facility remained out of compliance with this provision.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	**NEO Orientation** NEO orientation should contain the following elements: ▪ Lifting and transfers; ▪ Positioning (Alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. At CCSSLC, the PNM related core competencies (i.e., foundational skills) were comprehensive. The Facility reported from October 2012 through March 2013, 108 of 108 (100%) new	Noncompliance

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		employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs. The HT Department was refining its database to record new employee successful completion of the 22 PNM competency performance check-offs. At the time of the review, a report with accurate data could not be produced. **PNM Core Competencies for Current Staff** Seven hundred and fifty-four of 754 (100%) current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. The Facility reported the data for this metric was obtained from a report of all currently employed "direct contact" staff required to complete foundational PNM core competencies. All tenured staff completed their initial foundation PNM training prior to October 2012. Staff will complete "Annual Refresher" training from this point forward. Although some staff had received the initial foundational training in October 2011, they were scheduled to complete annual refresher training to avoid staff being delinquent in receiving training. All staff were placed on a cycle that was spread over 12 calendar months to allow HT staff to provide greater individual attention and have smaller classes. There were approximately 60 to 65 staff scheduled per month. Twelve of 12 (100%) PNMP Coordinator staff responsible for training other staff successfully completed competency-based training and performance check-offs (i.e., 22 PNM competency check-offs) for PNM core competencies (i.e., foundational skills) prior to training other staff. **Annual Refresher Training** The following metric could not be assessed: ▪ _____ of _____ current staff that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months. The Facility reported that 221 staff were in compliance with Annual Refresher training. However, the Facility was unable to provide an accurate number of staff required to complete the training in order to produce a compliance percentage. The Competency Training Department (CTD) department changed over to a new computer system and they were unable to retrieve data for the months of October, November and December 2012. There was training data for the months of January, February, and March 2013. However, an analysis of the training data for these months revealed data inaccuracies. The Facility reported they would continue to refine the database to provide accurate training data to produce an accurate and reliable compliance percentage. The Monitoring Team will assess this during upcoming reviews.	

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		Individual Specific Training Staff should receive an in-service training on PNMPs prior to their implementation. This should include all direct support professionals, including pulled/relief staff, responsible for specific individuals with physical or nutritional management problems, providing care that is affected by the PNMP. This review should consist of sharing of information about the core competencies (i.e., foundational skills) that are included in the PNMP. If more individualized supports are needed, further training should be provided, and is discussed in one of the metrics below. The following metric could not be assessed: ▪ For ___ of ____ staff assigned to individuals with PNMPs in Sample O.1 and O.2, (%) there is evidence of exchange of the information included in the PNMP prior to the provision of services. At the time of the review, the Facility could not produce a list of staff who had provided supports to individuals in the sample from October 2012 to March 2013. However, as reported above, current staff and new employees had completed PNM foundational performance check-offs. At the time of the review, there were five individuals' staff who received individual-specific training (i.e., non–foundational). One of these five individuals (i.e., Individual #270) was in Sample O.2. The Facility was not able to produce a list of staff who had provided supports to Individual #270 from October 2012 to March 2013 with the purpose of assessing compliance with individual-specific training. However, the Director of HT recommended the Monitoring Team review observation notes to determine if staff had received individual-specific training for Individual #270. The Facility provided staff observation notes from 3/17/13 to 3/31/13. The Monitoring team analyzed the observation notes and the individual-specific training roster to determine if direct support professionals providing supports during this time period had completed individual-specific competency-based training and a performance check-off for positioning in a custom right sidelyer. ▪ Three of 16 (19%) staff completing daily observation notes and providing support to Individual #270 had completed individual-specific competency check-offs. Eighteen of eighteen therapy staff responsible for training other staff (100%) successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. At the time of the review, the approved trainers for individual-specific (i.e., non-foundational) training were seven SLPs, five OTs, and six PTs.	

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		The Facility did not have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The Facility had made significant progress in completing foundational PNM training for new employees and veteran staff, including the successful completion of 22 competency performance check-offs. Five individuals required individual-specific PNMP strategies. The Facility had initiated individual-specific training. However, a review of staff observation sheets over a period of 15 days for one individual indicated that a significant number of this individual's staff had not been trained. The Facility should ensure that staff working with individuals who require individual-specific PNMP strategies have successfully completed non-foundational competency-based training and performance check-offs. The Facility remained out of compliance with this provision.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility's System for Monitoring of Staff Competency with PNMPs** ▪ Monitoring tools did not include adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. ▪ Monitoring tools did not include adequate instructions. ▪ The staff conducting monitoring were not competent in the areas they were monitoring. Monitoring tools for the implementation of mealtime and positioning plans should be sufficient to identify whether or not staff fully and correctly implement the plans. Monitoring tools should have instructions. "Adequate" instructions would describe the methods as well as criteria for monitoring to ensure consistency across staff responsible for monitoring. The Facility should present evidence that the monitors have: a) successfully completed core competency training; b) successfully completed individual-specific competency-based training; c) successfully completed training on use of monitoring forms; d) been validated by clinicians on completion of monitoring forms; and e) are periodically revalidated. The Facility compliance monitoring report (i.e., for the months of August, September and October 2012) indicated the majority of monitoring was being completed during meals. This data was collected to establish a mealtime monitoring baseline. Based on report, this was purposeful and was intended to the be the original focus of monitoring "due to the fact that mealtime practices are most likely to provoke swallowing difficulties and pose undue risk of harm to an individual." The Facility did acknowledge that other activities might also involve risk (i.e., oral hygiene, medication administration, bathing, lifting, transferring and positioning). The HT department was in the process of refining the monitoring system to include monitoring other settings.	Noncompliance

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		The Facility further acknowledged inaccuracies in the compliance monitoring report in reporting an accurate number of monitored sessions. In addition, the report indicated that 705 of 710 (99%) monitoring sessions were in compliance. Based on interview, these compliance scores were not in alignment with HT Department therapist's observations. Consequently, the HT Department did not have confidence in the monitoring data. To correct these concerns, Dining Room monitors were added to provide an additional level of oversight in the dining rooms. These monitors collected data that indicated staff were "almost always" in compliance with implementation of PNMP strategies. However, direct observation by the Monitoring Team and Facility therapists during the on-site review substantiated that the data did not reflect staff implementation of PNMPs during mealtimes accurately. Further analysis of the data collected during mealtimes indicated that this was in part due to poorly worded questions on the monitoring form, discrepancy between demonstrated competency in training and assessing staff compliance during monitoring, and issues with the database being used to aggregate the data collected. To resolve these concerns, the Facility revised the data collection form, training curriculum and the database. Additionally, an inter-rater reliability component was added to the monitoring process and implemented in March 2013. These revisions should be helpful in moving the Facility forward to produce monitoring data that is accurate and therefore, useful in identifying and resolving problems. The PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, based on the following: ▪ One hundred percent of the monitoring forms focused on oral intake (meals and snacks); ▪ Zero percent of the monitoring forms focused on bathing; ▪ Zero percent of the monitoring forms focused on medication administration; ▪ Zero percent of the monitoring forms focused on Oral Care; and ▪ Less than one percent of the monitoring forms focused on positioning. The following metrics could not be completed, because the monitoring report did not include this information. The Monitoring Team will request this information during the next review: ▪ ____% occurred during first shift; ▪ ____% occurred during second shift; and ▪ ____% occurred during third shift. **<u>Monitoring for Individuals in Samples</u>** For none of the 15 (0%) individuals in Sample O.1, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' assessment and/or	

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		the individuals' plans/IHCPs. For none of six (0%) individuals in Sample O.2, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. For the three months prior to the review, none (0%) of the monitoring sessions per policy or the individuals' assessments and/or plans were completed timely. Monitoring should occur according to the schedule identified in policy and/or as individualized in the assessment and/or plan. In cases where the individual's clinical acuity necessitates a higher frequency of monitoring, it should occur at this frequency. The Monitoring Team was not able to score the following metrics as none of the monitoring forms identified problems. This will continue to be assessed during upcoming reviews. ▪ For the past three months, problems were noted on _____ of the ____ monitoring forms. ▪ Of these, documentation of adequate follow-up was provided on the form for ____ (___%). The Monitoring Team will assess this during upcoming reviews. The Facility should ensure that for the individuals whose scores fall below 80%, plans to address staff noncompliance are developed. "Adequate follow-up" should include plans with specific action steps that are measurable, and can be reasonably expected to correct the deficiency noted. The follow-up documentation should be included on the monitoring form. However, as noted with regard to Section O.4 and this section, the Monitoring Team and the Facility did not have confidence in monitoring data. The monitoring data did not accurately reflect staff implementation of PNMP mealtime strategies. Additionally, observations the Monitoring Team and Facility therapists completed in dining rooms indicated staff were not correctly implementing individuals' dining plans. Furthermore, the Facility was not monitoring other PNMP strategies, and as a result, did not have data to identify problems with staff implementation of PNMP strategies beyond mealtimes. In summary, the Facility was monitoring staff compliance with mealtimes, but additional work needed to be done to expand monitoring to include staff compliance with all PNMP strategies. The Facility had begun the process of expanding PNMP monitoring. Based on interviews with the HT Director, there was no confidence in the accuracy of the monitoring data and the Monitoring Team agreed with this assessment. The Facility had made revisions to the monitoring form, training curriculum and the database to address	

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		these concerns. The Facility remained out of compliance with this provision.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of Plans** None of the 21 (0%) individuals' records in Sample O.1 and O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. None of the 21 (0%) individuals' records in Sample O.1 and O.2 contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans were monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans. For none of the one (0%) individual receiving direct therapy (i.e., Individual #99), the record contained evidence that documentation was reviewed of the plan's effectiveness based on objective clinical data included in the plan. Because plans did not include clinical indicators to alert teams to changes in status, the following metrics could not be evaluated, but will be during upcoming reviews: ▪ _____ of the _____ individuals' records (%) showed a change of status based on the established clinical indicators. ▪ Of these, ___ (__%) contained evidence that, as appropriate, the team met and interventions were reviewed and changed, as appropriate in a timely manner. Fourteen of 21 (67%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. None of 21 (0%) individuals' with Trigger sheets included individualized triggers as indicated. None of 21 (0%) individuals' Trigger sheets were completed correctly. None of 21 (0%) individuals' Trigger sheets were reviewed by the RN on a daily basis. In summary, the Facility should implement an effectiveness monitoring system, which includes tracking of individualized clinical indicators and triggers to evaluate and report on the progress of individuals' risk action plans supports and services, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	Noncompliance

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O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	**Assessment of Individuals Who Receive Enteral Nourishment** The Facility's database maintained a list of individuals who received enteral nourishment. The Facility did have a sustainable system to maintain and update a list of individuals who were enterally fed. However, a Facility policy and/or procedure did not define how the list of individuals who receive enteral nutrition would be maintained and updated as individuals received a feeding tube and/or transitioned to oral eating. Based on a review of the individuals in Sample O.3, ten of 10 (100%) individuals who receive enteral nutrition were evaluated at a minimum annually. None of the 10 (0%) individuals evaluated had an appropriate evaluation to determine the medical necessity of the tube. In order to determine medical necessity of enteral nutrition, documentation must include the discussion of the following areas: ▪ Nutritional assessment of current type of formula and schedule; ▪ Identification of primary medical diagnoses that contributes to the need for non-oral means of nutrition; and ▪ Assessment of Oral Motor status by SLP and/or OT to provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate. None of the five individuals admitted since the last review received enteral nourishment. As a result, the following metric was not evaluated, but will be, as applicable, during upcoming reviews: ▪ ____ of the ____ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** None of the 10 (0%) individuals in Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. All individuals receiving enteral nutrition should be assessed annually by the IDT to determine if improvements can be made to progress towards a less restrictive diet. This means the individual should be: ▪ Assessed by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual is a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as part of assessment findings. • Assessed by the Nutritionist/Dietitian regarding current formula and schedule of feedings and determine if there is a possibility for modification to a least	Noncompliance

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		restrictive schedule. Justification for/or against medication of formula/schedule should be included as part of assessment findings. None of the two (0%) individuals (i.e., Individual #134 and Individual #68) who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. The plan should include all of the following components: ▪ Staff training required prior to implementation; ▪ Staff roles and responsibilities (e.g., implementation, and monitoring); ▪ Time and schedule of interventions; ▪ Specific triggers for when the plan should be stopped; ▪ Milestones for progressing with the plan; ▪ Documentation requirements (i.e., method for tracking progress); and ▪ Frequency of subsequent assessments and staff responsible. None of the two (0%) individuals' plans to return to oral eating were based on the results of the IDTs' discussion and integrated in the IHCP, ISP, and/or an ISPA. The IRRF should provide clinical assessment data to identify an individual's potential to return to oral eating and provide justification for the medical necessity of the feeding tube. Any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. None of the two (0%) individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. The IHCPs should include timeframes consistent with the clinical needs of the individual. The IHCPs should be implemented according to the timeframes included, unless a reasonable explanation is provided and steps are provided to implement the action plan. None (0%) of the staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. Training conducted by the licensed clinician would include a return demonstration. None of the two (0%) individuals' plans were monitored as outlined in the plan. Individuals' plans should be monitored to meet the frequency and requirements in the plan and should be conducted by monitors who had demonstrated competency in the plan. None of two (0%) individuals' plans were modified by the IDT. For none (0%) of these individuals' plans, the IDT met and reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the	

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		plan is being implemented as written, staff are adequately trained, etc. In addition, if the team determines interventions are not effective, the IDT should revise these interventions. Plans should be revised within 24 hours or sooner if is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. In summary, the Facility remained out of compliance with this provision. The HT Department database maintained and updated a list of individuals who received enteral nutrition. However, this process was not captured in Facility policy and/or procedure. Individuals in the sample who received enteral nutrition were reviewed by the IDT, but the annual assessment did not include essential components. Individuals who were transitioning to oral eating did not have a formal plan.	

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

1. The Facility QA/QI process should define the pathways for how the PNMT will bring systemic issues to the attention of Facility Administration and work collaboratively to resolve these issues. (Section O.1)
2. Individuals' PNMT assessments, action plans/IHCPs and discharge summaries should include the essential components discussed with regard to Section O.2. (Section O.2)
3. The Facility PNM policy should define the PNMT Discharge process. (Sections O.1 and O.2)
4. The Facility should ensure individuals' PNMPs contain essential components as discussed with regard to Section O.3. (Section O.3)
5. When revisions to PNMPs occur, an ISPA meeting should be convened to provide IDT members the opportunity to discuss the revisions, make adjustments, if necessary, and agree on the final revisions. (Section O.3)
6. Per State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. (Section O.3)
7. The PNMT and IDT members should provide additional support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. (Section O.4)
8. The Facility should ensure staff working with individuals who have individual-specific PNMP strategies have successfully completed competency-based, individual-specific training and performance check-offs. (Section O.5)
9. The Facility should assess the success of revisions to the monitoring system. Part of this analysis should assess if the monitoring activities produce valid and reliable data to determine staff competence and compliance in safely and appropriately implementing PNMPs and dining plans. If not, continued revisions should be made to the form(s) and/or instructions, and/or additional training should be provided to those implementing the forms. (Section O.6)
10. The Facility should implement an effectiveness monitoring system to evaluate and report on the progress of individuals' risk action plan supports and services, and revise interventions as appropriate. (Section O.7)
11. The Facility should formalize the database procedures to maintain and update an accurate list(s) of individuals who receive enteral nutrition. (Section O.8)
12. Individuals who receive enteral nutrition should receive an assessment that includes the essential components discussed with regard to Section O.8. (Section O.8)

13. Individuals who are recommended for and/or are transitioning to oral eating should have a plan developed that includes the essential components listed in Section O.8. (Section O.8)

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 For the following 15 individuals, including individuals identified with PNM concerns, and/or who had experienced a change of status as evidenced by admission to the emergency room, and/or hospital, and/or received direct therapy intervention(s): (i.e., Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99), the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, the Hospital Liaison Nurse reports for individuals hospitalized within this sample across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o Facility policies and procedures related to the provision of OT/PT supports and services; o Organizational chart of Habilitation Therapy Department; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and CVs for new hires; o Continuing education completed by OTs and PTs, since the Monitoring Team's last onsite visit; o List of individuals who use a wheelchair as primary mobility; o List of individuals with transport wheelchairs; o List of individuals with other ambulation assistive devices;

	o List of individuals with orthotics and/or braces; o Physical Nutritional Management Maintenance Log; o OT/PT Assessments and Updates (templates) with changes made since the Monitoring Team's last review; o Tracking Log of completed individual assessments; o Wheelchair seating and PNM clinic assessment (templates); o Compliance Monitoring form template; o Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans; o Summary reports and monitoring results related to OT/PT; and o List of individuals receiving direct OT and/or PT services and focus of intervention. ▪ **Interviews with**: o Dr. Angela Roberts, Director of Habilitation Therapy; o Paul Osborne, PT, Physical Therapy Director and Co-Lead for Section P; and o Walter Shull, PT, Co-Lead for Section P. ▪ **Observations of**: o Individuals in residences and dining rooms including Coral Sea, Pacific, and Atlantic.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 3/18/13. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT, Section P Lead, and Program Compliance Monitor: o The monitoring/audit tool the Facility used to conduct its self-assessment included: the State Section P Monitoring Tool and various Facility-developed audit tools to assess compliance with indicators presented in Monitoring Team reports. The Director of HT stated that the current Monitoring Tool did not accurately assess the Facility's current compliance status in each of the sections. The Director of HT wanted to revise the monitoring tool to incorporate the indicators/metrics from the Monitoring Team's report that more accurately assessed the status of compliance within each of the sections. o The Monitoring Team agreed that the current unrevised Monitoring Tool for Section P did not include adequate indicators to allow the Facility to determine the current state of compliance with Section P. However, the data presented in the Self-Assessment reflected the completion of activities/audits completed outside of the scope of the Monitoring Tool for Section P. These audits represented a positive move forward in monitoring compliance with Section P. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators/metrics that are relevant to making compliance determinations. The development of the template for the presentation of data was a very

	promising step forward in aligning the items to be monitored with the Monitoring Team's indicators/metrics. o The monitoring tool did include adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. However, the Self-Assessment did not identify how the sample was chosen. The Facility Self-Assessment should identify how sample sizes were to be chosen for each of the subsections, including sample sizes adequate to consider them representative. o The monitoring/audit tool did have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and the PCM continued to revise the monitoring tool guidelines. o The following staff/positions were responsible for completing the audit tool: the Director of HT and the PCM. o Adequate inter-rater reliability had been established between the Director of HT and the PCM. ▪ The Facility used other relevant data sources and/or key indicators/outcome measures, including, for example, information from the HT Department database. ▪ The Facility presented some data in a meaningful/useful way, but in other instances more work was needed. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as not being in compliance with subsections P.1, P.2, and P.4. This was consistent with the Monitoring Team's findings. The Facility rated itself as being in compliance with Section P.3. This was not consistent with the Monitoring Team's findings, because the Facility had not adequately implemented individual-specific training. ▪ The Facility data identified areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: Individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Individuals' OT/PT assessments were improved, but additional work needed to be done to ensure essential components were present. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. Individuals who had experienced a change in status had not received an assessment update. OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes were not adequate to provide the results of reviews of the effectiveness of programs/interventions and the individuals' progress with direct and/or indirect OT/PT supports. As discussed with regard to Section O.6 and O.7, the Facility did not have an adequate monitoring system

	for OT/PT services. The Facility did not have a policy with essential components defining the monitoring system. On a positive note, individuals' assistive equipment was repaired in a timely manner.

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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.	**Definition of Samples** ▪ **Sample P.1** is the same as Sample O.1 that consisted of a non-random sample of 15 individuals (i.e., Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99) who were chosen from a list provided by the Facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, and/or osteoporosis], require mealtime assistance, and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. ▪ **Sample P.2** consisted of one individual (i.e., Individual #99) who received direct OT/PT services that was chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. At the time of the review, only one individual received direct therapy. **Timeliness of Assessments** Three of three (100%) newly admitted individuals (i.e., Individual #338, Individual #59, and Individual #39) since the last review received an OT/PT assessment within 30 days of admission or readmission. Ten of 15 (67%) individuals' OT/PT assessments (i.e., Individual #182, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, and Individual #99) were dated as having been completed at least 10 days prior to the annual ISP. Seven of the 15 individuals in Sample P.1 had experienced a change in status. None of seven (0%) individuals had received an assessment update that was current within 12 months for individuals who were provided PNM supports and services. The following concerns were noted: ▪ Individual #327 was hospitalized on 12/13/12 with a discharge diagnosis of	Noncompliance

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		aspiration pneumonia and subsequent placement of a jejunostomy tube. She had experienced a change in her health status, but an assessment update had not been completed. ▪ Individual #350 was hospitalized on 11/13/12 with a discharge diagnosis of GI bleed and history of recurrent ulcer. He had not received an assessment update to address his change of status. ▪ Individual #110 was diagnosed with skin breakdown to her coccyx on 12/4/12. She did not receive an assessment update. ▪ Individual #299 was reported to have unexplained weight loss but this was not addressed in his OT/PT assessment, and an assessment update had not been initiated. ▪ Individual #182 sustained a tibia/fibula fracture on 1/25/13. She had not received an assessment update. ▪ Individual #340 was hospitalized on 10/2/12 with a discharge diagnosis of emesis, fever, and a decrease in oxygen. He was hospitalized again on 10/29/12 with a discharge diagnosis of a GI (gastrointestinal) bleed, and on 12/6/12 discharged with a ventral hernia repair and hypoxia. He had not received an assessment update after any of these hospitalizations. ▪ Individual #74's dining plan, dated 2/26/13, had been revised to respond to weight loss and increasing tremors. His dining plan indicated he was to be fed food and fluids by staff. He had not received an assessment update to address his change in health status. **<u>OT/PT Assessment</u>** Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments was as follows: ▪ Fourteen of 15 (93%) individuals' OT/PT assessments (i.e., Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #340, Individual #251, Individual #67, Individual #110, Individual #74, Individual #299, Individual #327, Individual #350, and Individual #99) were signed and dated by the clinician upon completion of the written report. ▪ Nine of 15 (60%) assessments (i.e., Individual #182, Individual #126, Individual #260, Individual #218, Individual #251, Individual #67, Individual #299, Individual #350, and Individual #99) included diagnoses and relevance to functional status. ▪ Fifteen of 15 (100%) assessments included a section that reported health risk levels associated with PNM supports. This information should be utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. ▪ None of 15 (0%) assessments included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years	

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		or assessments. The OT/PT assessment should provide an overview of an individual's health status over the past year. The therapist should discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status. ▪ None of 15 (0%) individuals' OT/PT assessments offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. The OT/PT assessment should provide an overview of the past assessment results with the current assessment data for functional motor and activities of daily living skills. The assessment analysis should discuss the individual's performance and present data to support if the individual has remained the same, has improved, and/or has regressed within the areas of functional motor and activities of daily living. ▪ Four of 15 (27%) assessments (i.e., Individual #232, Individual #260, Individual #218, and Individual #251) included medical history and relevance to functional status. The medical history refers to medical conditions that would impact the provision of OT and PT supports and services. ▪ Three of 15 (20%) assessments (i.e., Individual #232, Individual #260, and Individual #327) addressed health status over the last year. ▪ Fifteen of 15 (100%) assessments listed medications and potential side effects relevant to functional status. ▪ None of 15 (0%) assessments included documentation of how the individual's risk levels impacted their performance of functional skills ▪ Twelve of 15 (80%) assessments (i.e., Individual #232, Individual #182, Individual #260, Individual #218, Individual #340, Individual #251, Individual # 67, Individual #74, Individual #327, Individual #350, Individual #245, and Individual #99) included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ None of 15 (0%) assessments included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings ▪ None of 15 (0%) assessments included discussion of the expansion of the individual's current abilities. The OT/PT assessment should discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs. ▪ None of 15 (0%) assessments included discussion of the individual's potential to develop new functional skills. ▪ Ten of 15 (67%) individuals' OT/PT assessments (i.e., Individual #232, Individual #182, Individual #126, Individual #260, Individual #218, Individual #251, Individual # 67, Individual #74, Individual #350, and Individual #99) included individual preferences, strengths, and needs. The preferences listed should be derived from the Preferences and Strengths Inventory (or other	

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		relevant document) developed by the individual's team. ▪ Three of 15 (20%) assessments (i.e., Individual #218, Individual #251, and Individual #67) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ None of 15 (0%) assessments identified the need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. The OT/PT assessment analysis section should provide clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs. ▪ None of 15 (0%) assessments included a monitoring schedule. The OT/PT assessment should discuss monitoring results from the previous year and recommend the implementation of a monitoring schedule for the upcoming year. The therapist should describe the monitoring form(s) to be utilized. ▪ Eleven of 15 (73%) assessments (i.e., Individual #182, Individual #126, Individual #260, Individual #340, Individual # 67, Individual #74, Individual #299, Individual #327, Individual #350, Individual #245, and Individual #99) included a reassessment schedule. ▪ Fifteen of 15 (100%) individuals' OT/PT assessments made a determination about the appropriateness of transition to a more integrated setting. As required by State Office, therapists had included their opinion about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needs were missing in the community. ▪ Fifteen of 15 (100%) assessments included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. ▪ None of 15 (0%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The Monitoring Team requested OT/PT comprehensive assessments and assessment updates (i.e., assessment of current status). At the time of the review, the OTs and PTs were completing comprehensive assessments and had not completed assessment updates for individuals who had experienced a change in status. There were nine individuals (i.e., Individual #67, Individual #327, Individual #360, Individual #110, Individual #299, Individual #182, Individual #126, Individual #340, and Individual #74) who had experienced a change in status (i.e., hospitalization related to PNM concerns, fracture, skin breakdown, and/or unexplained weight loss) after the completion of these individuals' comprehensive OT/PT assessment. These individuals	

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		should have received an assessment update. The following metric could not be assessed due to the fact that assessment updates had not been completed: ▪ For _____ of ____ (0%) individuals for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data. In summary, individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Individuals' OT/PT assessments were improved, but additional work needed to be done to ensure essential components were present. The OT/PT assessment template and audit tool should be reviewed to ensure the essential components for OT/PT assessments are incorporated. Individuals who had experienced a change in status had not received an assessment update. The Facility remained out of compliance with this provision.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**OT/PT Interventions** For individuals receiving OT/PT supports and services, four of 15 (27%) PNMPs (i.e., Individual #260, Individual #218, Individual #67, and Individual #10) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. However, the remaining 11 individuals in Sample P.1 had their PNMPs revised after the annual ISP meeting, but there was not an assessment update and/or an ISPA meeting documentation to address these revisions. For two of 15 (13%) individuals (i.e., Individual #218 and Individual #245), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. All recommendations should be considered, included as appropriate, or justification provided for not including them. **Direct OT/PT Interventions** At the time of the review, there was one individual (i.e., Individual #99) receiving direct therapy intervention. The records of the one individual in Sample P.2 were reviewed resulting in the following findings: ▪ One of one (100%) individual's direct intervention plans were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. ▪ For none of one (0%) individual's records reviewed, the current OT/PT	Noncompliance

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		assessment identified the need for direct intervention with rationale. The OT/PT assessment did not include an analysis of assessment data to provide justification for initiation of the direct therapy intervention. ▪ For none of one (0%) individual's records reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. The following metric was not applicable to Individual #99. However, it will be assessed during upcoming reviews. ▪ For ___ of ____ individuals' records whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. The therapist should provide clinical justification for the termination of a direct intervention plan. The team discussed the recommendation to terminate the program within 10 working days, and the team's decision was documented through an ISPA meeting. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O.4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** Nine of the 15 (60%) individuals' annual ISPs in Sample P.1 noted that the OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. OTs attended for Individual #126, Individual #251, Individual #74, and Individual #350. PTs attended for Individual #232, Individual #182, Individual #218, Individual #110, and Individual #245. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. Generally, for individuals receiving direct therapy, the therapist should attend the meeting. No OT and/or PT attended the ISP meeting for Individual #99 who received direct therapy. In assessing this requirement, the Monitoring Team reviewed the ISP Preparation Meeting documentation that should have included such information, as well as the ISP sign-in sheets. However, the ISPs attendance signature sheets were not present for the remaining four individuals' (i.e., Individual #260, Individual #340, Individual #67, and Individual #299). Two of 15 (13%) individuals' ISPs or ISPAs (i.e., Individual #218 and Individual #245) integrated the OT/PT interventions. The ISP or ISPA should describe the supports based on the rationale provided in the therapy assessment.	

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		In none of the four (0%) ISPs or ISPAs reviewed (i.e., Individual #269, Individual #74, Individual #245, and Individual #99), skill acquisition programs that had been recommended in the OT/PT assessment were present. The remaining 11 individuals' OT/PT assessments in the sample did not recommend skill acquisition programs for these individuals. For none of the one individual in Sample P.2 (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. None of the one (0%) individual receiving direct OT/PT Services was provided with comprehensive progress notes (IPNs). The progress notes should: ▪ Contain information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). ▪ Describe the benefit of the goal to the individual. ▪ Report the consistency of implementation. ▪ Identify recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. ▪ Be completed on at least a monthly basis. ▪ Based on the therapist's monthly data, if a lack of progress is noted, team review occurs to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT revises these interventions For individuals with PNMPs or SAPs, for none of the 15 individuals (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. For individuals who received indirect OT and/or PT programs (i.e., PNMPs), monthly documentation from the OT and PT and/or QDDP should include: ▪ Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); ▪ A description of the benefit of the program; ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. In summary, individuals' PNMPs had been revised, however, due to the absence of assessment updates it could not be determined if these plans had been implemented within 30 days. The one individual's direct therapy plan was implemented within 30	

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		days, however his OT/PT assessment did not provide a rationale for the direct therapy, his direct therapy was not integrated in the ISP and progress notes did not include essential components. An OT and/or PT had attended the annual ISP meeting for nine of the 15 (60%) individuals in the sample. OT/PT assessments that recommended skill acquisition programs had not been integrated in the ISP. Multiple OT/PT assessments did not recommend skill acquisition programs for individuals with identified needs. The Facility remained out of compliance with this section.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	The requirements for this section were discussed in detail with regard to Section O.5.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. Monitoring of PNMPs is discussed in detail with regard to Section O.6. The Facility did not have a comprehensive OT/PT policy that included the following elements: ▪ Description of the role and responsibilities of OT/PT; ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Defines the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Defines the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Includes monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identifies monitors and describes their roles and responsibilities; ▪ Defines a formal schedule for monitoring to occur; ▪ Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identifies the frequency of assessments; ▪ Defines how individuals' OT/PT needs will be identified and reviewed; and	Noncompliance

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		▪ Sets forth documentation expectations for individuals receiving direct services. For 15 of 15 (100%) individuals, routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Routine maintenance meant that therapists or designated staff reviewed equipment at least monthly. A database report for all Technician Work Orders completed for individuals at CCSSLC and Residences from 1/1/13 to 3/31/13 were reviewed. The data fields included start and end date, status of service, priority assigned, overall status, type of work completed and parts. For 286 of 286 (100%) individuals for whom adaptive equipment was noted to be in disrepair or needing replacement, the equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, then action was taken within 48 hours. None of the 286 repairs completed exceeded 30 days. On a positive note, for many of these individuals the repairs to their assistive equipment were completed within one day. In summary, as discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for individual OT/PT needs. The Facility did not have a policy with essential components to define the monitoring system. On a positive note, individuals' assistive equipment was repaired in a timely manner.	

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

1. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential components are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure they are comprehensive as required by the Settlement Agreement. In addition, the OT/PT assessment audit form should include these components. (Section P.1)
2. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISP meetings should include attendance by an OT and/or PT unless the team provides justification; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.2)
3. The Facility should ensure the development and implementation of a direct therapy intervention plan for individuals receiving direct therapy. (Section P.2)
4. The Facility should ensure the completion of comprehensive progress notes related to OT/PT direct interventions and indirect programs, including:
    a. Information regarding whether the individual showed progress with the stated goal;
    b. A description of the benefit of the goal to the individual;
    c. A report on the consistency of implementation; and

d. Recommendations/revisions to the direct intervention, or OT/PT program as indicated, related to the individual's progress or lack of progress. (Section P.2)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of the following Documents:** o Any submitted, updated policies, procedures and/or other documents/protocols addressing the provision of dental care; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months: ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ Have refused dental services; ▪ Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed makeup appointment; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain (yes or no), dentist documentation of confirmed pain (yes or no), and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work; and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam. o Most recent comprehensive exams and other dental visits in prior six months for one individual from each residence. Including a copy from dental office's record of visit and copy from active record of same visit, including the source of documentation for each record provided for the following individuals: Individual #161, Individual #275, Individual #318, Individual #268, Individual #282, Individual #56, Individual #266, Individual #118, Individual #155, Individual #88, Individual #130, Individual #87, Individual #60, and Individual #293; o Five most recent off-site oral surgery consults and progress notes during the past six months for the following: Individual #285, Individual #343, Individual #53, Individual #163, and Individual #333; o List of abbreviations used in all dental records/reports; o For the past six months, any data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans;

	o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for appointment (e.g., prophylaxis, annual, etc.) name, reason for appointment, dates of refusals and date of completion; o List of those who have not seen Dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current professional standards, and type of x-ray that is needed to fulfill requirement/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last on-site visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months, including type of appointment (e.g., prophylaxis, annual, etc.); o List of no shows/missed appointment per residence per month for the last six months; o List of refusals per residence per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow up appointment scheduled, whether follow up completed, any correspondence to QDDP, residential manager, team, etc.); o QDDP IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows during the last six months, including any ISPAs that documented discussion/action plans concerning dental refusals; o For five of the most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of dental department evaluation and treatment for the following individuals: Individual #255, Individual #61, Individual #40, Individual #280, and Individual #59. o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled, but the appointment was not completed, and the reason; o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc., for the following individuals: Individual #132, Individual #70, Individual #46, Individual #181, Individual #68, and Individual #42; o For the past six months, copies of any correspondence concerning restraint and sedation use at office visit (e.g., to QDDP, team, psychologist, etc.); o Copy of complete dental records for prior three years at CCSSLC, including progress notes (e.g., prophylactic, annual, emergency, restorative, etc./forms) completed, x-ray consult reports, restraint checklist, oral surgeon consultations, etc., for one individual most recently seen from each residence, as well as table format with name, dates of annual exams, prophylactic exams, and dates of other

	treatment. Records for the following individuals were submitted: Individual #62, Individual #34, and Individual #201; o For 10 individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring (including pre-treatment sedation sheets). Information was provided for the following individuals: Individual #126, Individual #260, Individual #4, Individual #205, Individual #124, Individual #93, Individual #321, Individual #91, Individual #187, and Individual #136; o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as PO sedation, IV or general anesthesia; o Copy of any restraint and sedation tracking list/system used by the dental department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach [lower dosage, less mechanical restraint duration, etc.]); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, copy of initial evaluation for this procedure, second opinion, and subsequent documentation until closure, for the following individuals: Individual #255, Individual #132, Individual #124, Individual #163, and Individual #333; o For those completing annual exams in the past six months, oral hygiene rating in each exam listed per individual and date of exam; o List of those who receive suction tooth-brushing treatment; o Copy of 10 annual dental assessments completed in the last 30 days and for the prior year of these same individuals: Individual #244, Individual #174, Individual #90, Individual #93, Individual #282, Individual #56, Individual #130, Individual #336, Individual #91, and Individual #308; o Dates of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record; o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #223, Individual #260, Individual #275, Individual #144, Individual #7, Individual #50, Individual #130, Individual #53, Individual #60, and Individual #321; o The most recent/current Facility oral hygiene data, including numbers and percentages of good, fair, poor ratings, with date of data; o For those that are edentulous, list of those with dentures;

	○ For those edentulous without dentures, list of reasons with documentation as indicated; ○ List of those who have been identified as benefiting from suction tooth brushing treatment, but who are not receiving suction tooth brushing, with reason; ○ For those individuals for which care plans/ISPs indicate they brush their own teeth, the oral hygiene scores, with dates of the scores over the prior year; ○ List of those individuals that floss their own teeth; ○ List of individuals provided instructions on flossing with dates of training; ○ Summary information on desensitization plans since Monitoring Team's last visit; ○ For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; ○ For those with documented pneumonia, for each individual, date pneumonia documented, date of most proximal dental visit prior to the pneumonia, type of procedure/visit completed, and type of anesthesia (i.e., TIVA, oral, local, none, etc.) in past six months; ○ For those individuals that brush their own teeth but do not floss, the reason for not flossing their own teeth; ○ For the self-assessment process: a list of monitoring/audit tools used, and any inter-rater reliability data that was obtained for the audit/monitoring review; ○ For the self-assessment process: a list of databases utilized; and ○ Presentation Book for Section Q. ▪ **Interviews with:** ○ Enrique Venegas, DDS, Dental Director.
	Facility Self-Assessment: For Section Q, in conducting its self-assessment, the Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring /audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data as well as interviews with staff: ▪ The monitoring/audit tools the Facility used to conduct its self-assessment included the following: Settlement Agreement Cross Referenced with ICF-MR Standard Section Q. ▪ These monitoring/audit tools included some indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators that are relevant to making compliance determinations. ▪ The monitoring tools included adequate methodologies, such as record reviews. ▪ The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). These sample sizes were adequate to consider them representative samples. ▪ The monitoring/audit tools did not include adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ▪ The following staff/positions were responsible for completing the audit tools: Dental Department

	staff, and the Quality Assurance nurse. ▪ Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. The Facility used some other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement are being reached. These included: missed appointments; current oral hygiene rating report; extractions monthly reports; preventative care monthly report; restorative care monthly report; no shows report; cancelled appointments report; refusals report; sedations report; TIVA sedation report; and monthly and quarterly dental trend report. Also utilized were databases from the Facility Training Department, pneumonia reports, ISP attendance, and HRC databases. The quality of the data maintained in the databases was noted to be complete and accurate. The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: ▪ Presented findings consistently based on specific, measurable indicators. ▪ Consistently measured the quality as well as presence of items. The Facility rated itself as not being in compliance with both Sections Q.1 and Q.2. This was consistent with the Monitoring Team's findings. The Facility data identified areas of need/improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying for example the need to implement desensitization programs.
	Summary of Monitor's Assessment: The Dental Department continued to provide consistent quality data for nearly every aspect of dental services. This was helpful in determining areas of strength and weakness. It was evident the Dental Department reviewed this information and applied it to the dental services for continuous improvement. Oral hygiene scores appeared to slowly improve. There was follow-up of refused appointments, as well as missed appointments. The breadth of services was provided. An ongoing concern for which little progress has been demonstrated was the desensitization program. Of concern, more recently, the Dental Department and Psychology Department had different lists of those individuals who might benefit from desensitization. This was a step that already should have been resolved. The quarterly reports appeared thorough, and included numerous pie charts and graphs, but a more succinct quarterly report with focus on the basic strengths, and challenges, and a summary of how the department was meeting those challenges would be an appropriate step. For those individuals who brushed their own teeth and had worsening oral hygiene ratings, a review for further interventions and assistance would be appropriate, along with closer tracking of their dental care in the residence and more frequent follow-ups in the dental clinic.

	The Dental Department needed to ensure policies and procedures covered all aspects of dental services.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	<u>Staffing</u> Two dentists, one Certified Dental Assistant, two Registered Dental Hygienists, and two Dental Medication Aides staffed the Dental Department. There were no staff vacancies in the Dental Department. CPR certification was submitted for the Dental Department staff. For seven of seven (100%) of dental staff, CPR was current. CPR recertification was due for one Dental Department staff during March 2013, but was still current at the time the list was generated on 2/21/13. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from July 2, 2012 through January 29, 2013, in a document entitled "Annual Exams Due from August to February and Date Completed." These listed annual exams that were completed in the prior year (8/1/11 to 2/29/12) with dates for the current year from August 2012 through February 2013. There were a total of 142 individuals named. Of these 142, 141 (99%) had a current annual examination date completed within 365 days of the prior annual exam. There was one overdue annual examination, due to the residence being under isolation precautions. Separately, a database was submitted, entitled "Dates of dental record annual examination/assessment in the last six months," with a run date of 3/7/13. Listed were annual assessments completed from 7/13/12 through 2/21/13, the date the assessment was typed and available, and the date of the prior dental exam for determining timeliness of completion. This confirmed that one examination remained overdue. There were six additional assessments that were not available by the due date, because these had not been typed. The time from completion of the exam to a completed typed document ranged from four days to 36 days. It is recommended that a system be put in place to minimize the time from exam completion to report completion as other departments rely on timely reports. The Dental Department documented that there were zero individuals residing at CCSSLC who had not seen a dentist from 2/1/12 through 1/31/13. Separately, copies of 10 annual dental assessments that were completed in the 30 days prior to the Monitoring Team's visit along with the prior year's completed assessments	Noncompliance

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		were submitted. These were completed in February and March of 2013. For 10 out of 10 (100%) of these individuals, an annual dental assessment had been completed within 365 days. A copy was requested of the annual assessment and other dental visits in the six months prior to the Monitoring Team's visit, to be submitted from both the active record and the dental office notes for 15 individuals. The active record section submitted was the dental section of the active record. Dental IPN entries in the IPN section of the active record referred to the reader to the dental section of the active record. The following findings were made with regard to the active record dental section notes and dental office notes related to the annual assessments and other documentation in the prior six months: ▪ Fifteen of the 15 (100%) individual annual assessments had an identical entry in both the dental office record and active record. ▪ Fifteen of the 15 (100%) annual dental summaries had an identical entry in both the dental office record and active record. ▪ Nine of nine (100%) individual sedation reports had an identical entry in both the dental office record and active record. ▪ Forty-six of 46 (100%) of the submitted IPNs/DPNs had an identical entry in both the dental office record and active record. ▪ Discrepancies included the following: o Six of 14 (43%) individuals had a missed appointment log submitted from the dental office record. Zero of 14 (0%) individuals had a missed appointment log submitted from the dental section of the active record. The missed appointment log appeared to not be filed in the active record. Copies of the completed annual dental assessments and annual dental summaries (provided to the IDTs) were submitted. The content of this submitted document for IDT review (i.e., annual dental summaries) included the following components: ▪ Ten of the 10 (100%) annual dental summaries had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) annual dental summaries had entries for oral hygiene rating. ▪ Ten of the 10 (100%) annual dental summaries for individuals with teeth had entries for teeth restorations, and periodontal condition. None were edentulous. ▪ Ten of the 10 (100%) annual dental summaries had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening)/soft tissue exam). ▪ Ten of the 10 (100%) annual dental summaries documented findings/treatment of the annual visit. ▪ Ten of the 10 (100%) annual dental summaries documented a summary of findings/treatment during other dental visits, including the number of	

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		exams/missed appointments, and cancellations. ▪ Ten of the 10 (100%) annual dental summaries included dental recommendations and action steps. ▪ Ten of the 10 (100%) annual dental summaries documented oral hygiene recommendations. ▪ Ten of the 10 (100%) annual dental summaries documented risk rating. ▪ Ten of the 10 (100%) annual dental summaries documented appropriateness for community transition. Additionally, during the time period from 8/1/12 through 2/28/13, there were three new admissions. Two out of three (67%) had completed an initial dental exam in the first month (with range of time to initial evaluation from eight to 53 days). <u>Review of dental records for the prior three years</u> The Facility was asked to submit the complete dental records for the prior three years for one individual from each unit as a separate measure of completeness and timeliness in dental documentation. Three records were submitted, and the following findings were based on the review of this material: ▪ For three of three (100%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ Zero of three were edentulous. ▪ For those with teeth, a periodontal chart or periodontal screening record was completed/documented in three of three (100%) records. ▪ The dental treatment plan was documented in three of three (100%) records. ▪ One of three individuals had undergone tooth extraction in the prior three years. For an additional individual, there was a need for an extraction o The need was documented twice (10/15/12 and 1/22/13), but the extraction had not occurred at the time of the submitted information. ▪ One of three individuals had undergone restorative dentistry in the prior three years. ▪ Zero of three individuals had undergone emergency treatment. ▪ Three of three had undergone TIVA/ general anesthesia in the prior three years. ▪ There were five visits under TIVA/general anesthesia for these three individuals in the prior three years. o Consents for three of three (100%) TIVA/general anesthesia procedures in the prior three years were submitted. o Three of three (100%) had undergone medical clearance for TIVA in the prior three years. o Three of three (100%) had undergone anesthesia clearance for TIVA in the prior three years. ▪ One of three had oral surgery in the community in the prior year.	

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		▪ Three of three (100%) had a current annual dental summary (utilized by the IDT). ▪ For three of three (100%), the most recent two annual dental summaries were completed within 365 days of the prior annual dental summary. ▪ Three of three (100%) had information submitted documenting completion of dental x-rays within the prior three years. Two of three (67%) had x-rays completed in the prior year. ▪ The level of cooperation and need for sedation/restraint in the prior year was documented in three of three (100%) records. ▪ The current oral hygiene rating was recorded in three of three (100%) records. All three had several oral hygiene rating scores documented. ▪ The level of risk for dental needs was recorded in three of three (100%) records for the most recent year. ▪ Tooth-brushing instruction was documented in three of three (100%) records. ▪ The recommendations for oral hygiene instruction (e.g., tooth-brushing recommendations/flossing, etc.) were recorded in three out of three (100%) records. ▪ A statement of appropriateness for community transition was recorded in three out of three (100%) records. <u>Oral Hygiene</u> An oral hygiene index was completed on each individual (that has teeth) at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire Facility in a document entitled "Current Oral Hygiene Ratings," dated 2/5/13. According to this document, for a census of 249 individuals, 134 (54%) had a good oral hygiene score, 80 (32%) had a fair oral hygiene score, and 35 (14%) had a poor oral hygiene score. From a separate list entitled "Annual exams completed in the last six months, the oral hygiene rating in each exam, listed by date and individual," dated 3/8/13, appointments from 8/1/12 through 2/28/13 were listed. Of these, 145 individuals completed the appointment and allowed an oral hygiene rating to be completed. Of these, 75 of 145 (52%) had an oral hygiene rating of good, 48 (33%) had an oral hygiene rating of fair, and 22 (15%) had a score of poor. This more recent list, indicated maintenance of oral hygiene ratings, with over 80% of individual maintaining fair or good oral hygiene. The document entitled "CCSSLC Dental Services Department Monthly Trending Report'" tabulated the oral hygiene scores monthly. For the time period from August 2012 through February 2013, oral hygiene ratings were completed on 667 individuals. Three hundred seven (46%) individuals had good oral hygiene. Two hundred fifty (38%) individuals had fair oral hygiene. One hundred ten (17%) individuals had poor oral	

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		hygiene. August 2012 data and February 2013 data were compared to determine any change in oral hygiene ratings during this period of time. In August 2012, there were 111 ratings completed. Forty-six (41%) individuals had good oral hygiene, 46 (41%) individuals had fair oral hygiene, and 19 (17%) individuals had poor oral hygiene. In February 2013, there were 134 ratings completed. Sixty-one (46%) individuals had good oral hygiene. Fifty-three (40%) individuals had fair oral hygiene, and 20 (15%) individuals had poor oral hygiene. Although the denominator per month was small, these numbers suggested an increase in the numbers of individuals with a good oral hygiene rating, and a decrease in the number of individuals with a poor oral hygiene rating. These percentages for August 2012 and February 2013 were different than the calculations in the 3/8/13 document, "Annual exams completed in the last six months, the oral hygiene rating in each exam, listed by date and individual." The reason for the discrepancy was not clear. <u>Suction Tooth-brushing</u> As part of preventive oral care, suction tooth brushing was provided to those with dysphagia and other indications for this procedure. A list submitted indicated 36 individuals received suction tooth brushing, which was 36 out of 246 (15%) of the population. Zero additional individuals were identified as qualifying for suction tooth brushing. According to the Facility, all individuals identified as candidates received suction tooth brushing. <u>Tooth brushing</u> The Dental Department provided documentation of tooth brushing instruction for the individual and/or staff while the individual was in the dental clinic or when an in-home exam/demonstration was conducted. The number of trainings per month was provided as follows: ▪ As of 1/10/13, 545 of 575 (95%) staff received classroom instruction concerning oral care through an "Ilearn video." There was also a new employee orientation training class on oral hygiene. ▪ Dental Department staff provided training for individuals and staff in the dental office and in the residence. o The numbers of staff trained "hands on" was submitted. From a document dated 2/14/13, 368 of 515 (71%) current employees had been trained "hands on" concerning dental care. It was noted that a number of staff that had left employment at CCSSLC had been trained. The large number of new employees listed was an ongoing challenge in ensuring oral care training. There was no information as to the	

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		effectiveness of these many trainings in the clinic and in the residence. Information was not available to determine whether the trainings were competency-based. It is recommended that the Dental Department provide updated training rosters and percentage of total staff trained for the hands on training, classroom training, and Ilearn video training, etc., on a monthly or quarterly basis. Seventy-five individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores for these 75 individuals were submitted for the prior two ratings completed at the time of the annual exam. ▪ Thirty-six of 75 (48%) remained in the same category of oral hygiene rating. o There were five that maintained a good oral hygiene rating. o There were 13 that maintained a fair oral hygiene rating. o There were 18 that continued to have a poor oral hygiene rating. For these 18 individuals, it was not determined whether the IDT and/or the Dental Department had identified the need for additional assistance/steps or review of the plan for brushing one's own teeth. ▪ For 10 of 75 (13%) individuals that brushed their own teeth, there was improvement in the oral hygiene ratings. o For three individuals the ratings improved from poor to fair. o For seven individuals the ratings improved from fair to good. o For zero individuals, the ratings improved from poor to good. ▪ For 29 of 75 (39%) individuals, the oral hygiene ratings worsened o For 17 individuals, the rating changed from good to poor. o For five individuals, the ratings changed from good to fair. o For seven individuals, the ratings changed from fair to poor. It was not determined whether the IDT and/or Dental Department had identified this worsening in oral hygiene rating and whether steps had been taken to address this decline. <u>Flossing</u> The Dental Department indicated flossing was not an "established procedure" at CCSSLC, due to prior injuries sustained during flossing. Examples of injury included torn papillae, lip laceration, cuts to fingers, and reduction of blood circulation. A list of 46 individuals was submitted for whom flossing was allowed during dental procedures only. The Dental Department listed no individuals that flossed during self- care. A list of individuals was submitted that had received training on flossing or were to receive training. The list totaled 57 individuals and of these 40 had been trained. Thirteen of these vocalized interest in dental picks, and one indicated interest in flossing. It was not determined the extent of follow-up for the individual with interest in flossing.	

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		There were 27 individuals trained who did not have further interest in flossing. Reasons were not categorized, but included lack of interest in or refusing to consider flossing, limited ability to open the mouth, limited ability due to mood disorder, inability due to challenges of dexterity, history of SIB, history of pica, and inability to follow instructions. A smaller list of those individuals with independent tooth brushing skills was provided, along with the reasons for those individuals not flossing independently or with assistance. Nine individuals were listed as brushing independently. These individuals were also listed in the 57 noted above. Of these nine, five had been provided flossing instructions. Three were also trained on the dental pick. None preferred flossing, and three preferred the dental pick, although it could not be determined if the dental pick was to be used independently, while observed, etc. Reasons for not flossing appeared to be individual choice. One individual did not follow instructions and another chose not to learn. An additional individual was not a candidate for dental flossing, as only two teeth remained and they were not proximal. There were three individuals who brushed independently that had not been instructed at the time of the submitted information on 2/27/13. <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from 8/17/12 through 1/22/13, along with the date of the prior dental appointment and the procedure completed during that appointment. Of a list of 23 individuals that had pneumonia, the date of the most recent dental appointment was provided for all 23. Two individuals had dental appointments within eight days prior to the date of the pneumonia diagnosis. For one individual, pneumonia occurred within five days of the dental appointment. The dental visit was for a dental examination and no anesthesia was provided. The other individual developed pneumonia seven days after a dental visit for cleaning and fluoride treatment. There was no anesthesia given at this visit. There did not appear to be a trend based on submitted documents. However, the Dental Department should continue to track this information. <u>Preventive, Restorative, Emergency Dental Services</u> The Dental Department did provide the breadth of services required to care for the individuals at CCSSLC. From 8/1/12 through 2/28/13, 220 individuals were seen for prophylactic care. Nineteen individuals underwent 50 restorative procedures. Twenty-three individuals were seen and treated for 25 dental emergencies. Twenty-five individuals underwent dental extractions. The number of teeth extracted per individual ranged from one to seven per visit. One hundred twenty individuals completed an annual dental exam from 8/1/12 through 1/29/13. ▪ In August 2012, there were 53 preventive dental care visits.	

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		▪ In September 2012, there were 63 preventive dental care visits. ▪ In October 2012, there were 52 preventive dental care visits. ▪ In November 2012, there were 66 preventive dental care visits. ▪ In December 2012, there were 30 preventive dental care visits. ▪ In January 2013, there were 45 preventive dental care visits. ▪ In February 2013, there were 65 preventive dental care visits. During this time period, there were a total of 374 preventive dental care visits. ▪ Seven individuals underwent an extraction of one tooth. ▪ Six individuals underwent an extraction of two teeth. ▪ Four individuals underwent an extraction of three teeth. ▪ Four individuals underwent an extraction of four teeth. ▪ Two individuals underwent an extraction of five teeth. ▪ One individual underwent an extraction of six teeth. ▪ One individual underwent an extraction of seven teeth. *X-rays* The Dental Department referred to current professional standards in guiding the determination for ordering x-rays. According to the Dental Department, 14 individuals were overdue for recommended dental x-rays, listed as Category A (i.e., low priority, oral hygiene good/fair, no visible decay, severe bruxism, unable to stay still for x-rays, safety concerns such as pica or self injurious behavior, and limited dentition). Full mouth series had been completed in the past on 13 of 14 (93%), but the dates of x-rays ranged from 7/12/76 to 10/6/05. There were no individuals overdue that were recommended for dental x-rays, listed as Category B (i.e., medium priority, oral hygiene fair/poor, combative, pending TIVA candidate, psychotic, irrational behavior, and frequently refuses dental services). There was one individual listed as Category C (i.e., high priority, oral hygiene poor, decay present, mobility present, eminent need for dental restorations and/or extractions, and new admissions). This individual was a new admission and evaluation was pending as of 2/20/13. There were 17 individuals listed as Category Zero (i.e., no ability to take x-rays, anatomy of the oral cavity, medically compromised, contraindicated for TIVA dentistry, fixation of the temporo-mandibular joint, fragile health, serious or terminal health condition, and compromised airway). *Edentulous individuals/dentures* Information submitted indicated 18 individuals residing at CCSSLC were edentulous, for a rate of 18 out of 246 (7%). No individual had become edentulous since the Monitoring Team's last visit in July 2012. The eighteen individuals that were edentulous did not	

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		have dentures. Reasons given were: ▪ 18 (100%) inadequate cooperation for denture fabrication to be completed; and ▪ Nine (50%) complex oral anatomy. Four individuals at CCSSLC had dentures, but had mixed dentition. *Oral Sedation* Monitoring and evaluation of use of oral sedation was reviewed. Ten active records were submitted for individuals who underwent oral sedation and the following summarizes the results of this review: ▪ Four out of seven (57%) confirmed nothing by mouth (NPO) status or nothing per G-tube at the time of the dental visit. Three individuals were documented to not need NPO status. ▪ Ten of 10 (100%) listed the medication administered, the dose, and the route. ▪ Eight of 10 (80%) submitted pre-procedure vital signs in the home. ▪ Ten of 10 (100%) documented pre-procedure vital signs in the Dental Department. ▪ Ten of 10 (100%) had an examination note on the date of the visit. ▪ Eight of 10 (80%) documented intra-procedure vital signs or attempts at vital signs. ▪ Ten of 10 (100%) documented post- procedure vital signs. ▪ Adequate documentation regarding effectiveness of sedation was found in 10 of 10 (100%) of the active records. ▪ Three of 10 (30%) documented Dental Department follow-up the next business day. ▪ Ten of 10 (100%) included documentation of current sedation consent. ▪ Eight of 10 (80%) included documentation of HRC approval. ▪ Ten of 10 (100%) did not utilize a mechanical restraint. ▪ Ten of 10 (100%) included a restraint checklist. *General Anesthesia/TIVA* The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period from 8/1/12 through 2/28/13. The number of appointments utilizing general anesthesia/TIVA completed per month are as follows: ▪ August 2012 – nine; ▪ September 2012 – seven; ▪ October 2012 – eight; ▪ November 2012 – six; ▪ December 2012 – zero; ▪ January 2013 – zero; and ▪ February 2013 – seven.	

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		Four individuals did not complete the general anesthesia/TIVA appointment. A follow-up appointment was completed under general anesthesia/TIVA for one of four (25%) cases. Also submitted were nine individuals with appointments in March 2013. However, eight (89%) had a note attached which indicated "holding for isolation clearance." The active record was submitted for six individuals who had undergone general anesthesia/TIVA from November 2012 through February 2013. The procedures under general anesthesia/TIVA included one or more aspect of dental care. The list varied in each case, and included one or more of the following: extractions, restorations, cleaning, and/or x-rays. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was current (defined as completed and dated within 365 days of the procedure) in six of six (100%). ▪ HRC approval was submitted in six of six (100%). ▪ A pre-operative medical clearance was completed and submitted in six of six (100%) cases. ▪ A pre-operative anesthesia record/clearance by anesthesia was completed and submitted in six of six (100%). ▪ An operative note (IPN) by the dentist was recorded in six of six cases (100%). ▪ The operative anesthesia record was completed in six of six cases (100%). ▪ For those with teeth, an updated periodontal chart/periodontal screening record was submitted for four of five (80%) of applicable cases. Periodontal probing was documented in the dental IPN, but no measurements or updated periodontal chart was provided. For one individual, periodontal probing had been completed during TIVA three months prior to the current TIVA procedure. ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score was submitted in six of six (100%) of the active records. ▪ A Dental Department recovery note prior to discharge from the Infirmary was submitted for zero of six (0%). The dental staff wrote a follow-up recovery note in six of six (100%) when communicating with the residence the following day. Three of six (50%) had additional follow up dental IPNs. ▪ Pain medication was prescribed in two of two (100%) applicable cases in which extractions occurred. ▪ An annual dental assessment was completed while under general anesthesia/TIVA in six of six cases (100%). The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. For the time period from 8/1/12 through	

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		1/31/13, there were 29 completed appointments for individuals listed as having been scheduled for general anesthesia/TIVA. Of the 29 appointments involving TIVA, there were no incidents of injuries in the following 24-hour time period. All 29 post TIVA recoveries were described as "Normal recovery – no adverse reactions." *Extractions* For five individuals that underwent extractions at the Facility, the dental record was submitted and the following findings were made: ▪ From the submitted documentation, consent was current in five of five (100%). ▪ HRC approval was submitted for four of five (80%). ▪ A prior dental IPN/DPN indicating the need for extractions was documented in five of five (100%). ▪ For three of the five cases, IV sedation/general anesthesia was used. For one of the five cases, oral sedation (via g tube) with local anesthesia was used. One of five had only a local anesthetic. ▪ From one to three teeth were extracted at a visit. ▪ Documentation of pain medication treatment post procedure was provided in two of five (40%) cases. ▪ A follow-up dental note the following day or a phone call to the residence was documented in three of five (60%) cases. ▪ A follow-up visit was documented in four of five (80%) cases to determine healing or complications. For five individuals that underwent extractions off-site at the oral surgery consultant's office, the dental record was submitted. The following findings were made: ▪ Zero of the five had prior refusals for dental appointments or unsuccessfully completed appointments. ▪ Five of five (100%) had completed IPNs/DPNs in the record prior to referral to the oral surgeon indicating the need for the extraction or other procedure. ▪ Five of five (100%) included the reason for the visit and recommendations for oral surgery in the IPN/DPN visit. ▪ Five of five (100%) had additional IPNs written prior to the oral surgery appointment in the prior six months. ▪ Five of five (100%) included an oral surgery consult report. ▪ Between two and four teeth were extracted at the individual's oral surgery appointment ▪ An anesthesia report (including medication and dosage administered) was submitted for five of five (100%). ▪ There were one or more post-operative IPN/DPN notes from the SSLC Dental Department submitted for five of five (100%) off-site dental procedures.	

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		Emergency Treatment The Dental Department provided a "Dental Emergency Log" for the months of August 2012 through February 2013. These logs reflected 23 individuals with 25 emergencies. Of these 25 emergencies, 21 (84%) were seen the same day as the emergency contact with the Dental Department. The remaining four (16%) were seen within one business day. Of these four, three were seen the next day and one was seen in three days (after a weekend). The "Dental Emergency Log" tracked these emergencies to completion. Twenty-four of 25 were tracked to closure. There was one emergency seen the next day, with an additional appointment completed, with subsequent referral to an oral surgeon, so full closure had not yet occurred. This appointment was scheduled for 3/18/13. The document entitled "CCSSLC Dental Services Department Monthly Trending Report" confirmed 25 emergencies during the time period from August 2012 through February 2013. There were five emergencies in August 2012, two emergencies in September 2012, two emergencies in October 2012, zero emergencies in November 2012, two emergencies in December 2012, five emergencies in January 2013, and nine emergencies in February 2013. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: toothache due to periodontal abscess, discomfort in mouth caused by gingivitis with packed food, laceration due to SIB, complaint of red gums with exam with no dental findings, and teeth guarding and clenching. The following findings were based on this review: ▪ Five of five (100%) records documented the presence or not of pain. ▪ Pain was treated in three of three (100%) cases, which had pain. ▪ Follow-up when indicated occurred for four or four (100%) individuals. ▪ There was documentation of closure of the dental emergency in five of five (100%) cases. ▪ The length of time from the identification of the dental emergency in the residence to notification of the Dental Department occurred the same day as the occurrence of the problem. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit varied from 15 minutes to three days (if called in Friday afternoon or evening). Because of the scope and detail of the above information, the following summary of this section is provided to focus the Dental Department on areas necessary for substantial compliance to be achieved. There are many areas outlined above with 90% or greater compliance. Maintenance of these areas will be required. However, a few areas need	

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		further refinement. Newly admitted individuals should have dental exams within 30 days of their admission. Dental summaries should be completed in a timely manner to allow sharing with others team members. In addition, review is needed of those individuals who brush their own teeth, but have poor oral hygiene scores and/or whose oral hygiene ratings are worsening, and as appropriate, new plans should be implemented and results tracked. The Facility had made progress, but should continue its efforts to identify individual who can and are willing to floss their teeth. Pre-procedure and intra-procedure recording of vital signs when oral sedation is administered should be provided and documented, where applicable. It also is important to document whether an individual was made NPO when an order/expectation for NPO is included in the dental visit record, prior to initiating the dental procedure. Ensuring HRC approval had been obtained for procedures requiring it (e.g., use of sedation, etc.) was needed in some instances. These are all areas that appear to be challenges that the Dental Department can meet in the near future.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	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 the development of dental policies and procedures, provision of dental records to IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> Policies amended since the Monitoring Team last visit included the following: ▪ "Dental Care Services: Chlorhexidine with suction brush protocol," Policy #Q.21, revision 11/9/12. Training was conducted on 11/16/12, with five dental staff in attendance and training of nursing personnel was conducted from 11/14/12 through 11/19/12, with 96 staff in attendance. The Facility had a number of dental policies. The Dental Department should ensure that all the various dental services provided are reflected in policies and procedures. If not already developed/revised and implemented, policies should be considered for flossing; tracking the oral hygiene rating of individuals who brush their own teeth; dentures as an option in dental care at CCSSLC; tracking and trending of dental/oral care training at all sites and in all media to individuals, direct support staff, and nursing staff; further development of policies to address refusals of those with behavioral or opposition to appointments; formalizing the communication process with the QDDP and IDT concerning missed appointments and other concerns of the Dental Department; and policy/protocol development for those needing desensitization due to sensory defensiveness and/or anxiety.	Noncompliance

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		Refusals/Missed Appointments The "CCSSLC Dental Services Department Monthly Trending Report" reported attendance per month for dental services as follows:	

Appointment encounter	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013
Refused	9	9	5	10	10	7
No show	11	1	2	2	0	1
Cancelled	4	3	7	3	3	25
Completed	111	102	101	91	48	82
% Completion	82.2	88.7	87.8	85.8	75.4	71.3

The data changed over time for the same months, and the most recent information from January 2013 was utilized. This might have been due to more accurate information being available for some of the categories. The January 28, 2013 "Dental Team Meeting" documented there had been a problem in accuracy of the database concerning attendance, but that this had since been corrected. The August 2012 data had previously indicated that there were 180 completed appointments. This had dropped to 111 by the time of the January 2013 report. Inaccurate information was a concern as a review of the minutes of the Dental Department reports for the "QA/QI Quarterly Section Review of Settlement Agreement Progress," dated 9/25/12, had incorporated this inaccurate information.

A review of information from a document entitled "Individuals Identified to have refused dental treatment" provided names of individuals that refused dental appointments, during the time period from 8/1/12 through 2/28/13. The list totaled 35 individuals. This list did not indicate the dates/number of appointments refused for each individual. A separate list was submitted, entitled "List of refusals for the past six months per date of refusal" for the time period 8/1/12 through 2/28/13, although there was an entry for 3/4/13. From this information, the following was documented:

- Thirty-five individuals refused 43 originally scheduled appointments.
- Thirty-three follow-up appointments were subsequently completed.
- Nine follow-up appointments for these individuals were still pending/remained incomplete (the document scan date was 3/8/13).
- One appointment was refused and not rescheduled (the reason provided was "home under isolation").
- Fourteen individuals refused one or more make-up (serial) appointments. The breakdown of these appointments (both the original and make-up appointments refused) included:
    - Six individuals refused two appointments;

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		o Four individuals refused three appointments; o Two individuals refused four appointments; o One individual refused five appointments; and o One individual refused eight appointments. ▪ Reasons for the scheduled appointments that were refused included: o Cleaning - 11 appointments; o Extractions – zero appointments; o Cleaning and fluoride - 11 appointments; o Exam and cleaning – four appointments; o Annual/edentulous – two appointments; o Annual – three appointments; o Initial exam – one appointment; o Periodic exam – one appointment; o Restoration – three appointments; o Desensitization trial – two appointments; o Emergency – one appointment; and o Denture fitting, etc. - three appointments. ▪ The information did not identify the residences of the individuals. Separately, the "CCSSLC Dental Services Department monthly trending report" documented that there were 66 refusals from August 2012 through February 2013. This was different than the prior submitted information, but might be due to the method of counting serial missed appointments for the original missed appointment. The number of appointments documented totaled 824 appointments. The refusal rate for appointments was eight percent. For the 34 appointments that were refused and subsequently completed, the length of time between the original appointment date and the completed appointment date was able to be determined as follows: ▪ For 13 individuals, the completed appointments occurred from six to15 days after the refused appointment. ▪ For 11 individuals, the completed appointments occurred from 16 to 30 days after the refused appointment. ▪ For five individuals, the completed appointment occurred from 31 to 60 days after the refused appointment. ▪ For five individuals, the completed appointment occurred more than 60 days after the refused appointment. As a follow up to refused appointments, the Dental Department created an "ISPA Refusals Tracking Chart," starting the week of 1/25/13. This document listed, per week, those	

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		individuals that refused appointments according to the residence. The Dental Department also created a "Missed Dental Appointments" log, which listed the name, residence, and the appointment date with time missed, and whether it was no show, refused, or cancelled. A cancellation key was used to further define the reasons for the cancellation. Samples of correspondence to the QDDP/IDT were submitted. These included emails alerting the team; a chart that included the timeline of the individual's missed appointments; the dental procedure that was missed; whether the appointment was missed, no show, or cancelled; the reason provided to the Dental Department for the missed appointment; the make-up date of the missed appointment; and whether the appointment was completed. A formal consultation request was written to the IDT team "to evaluate and recommend options," which reiterated much of the information in the timeline document. There was also a document submitted entitled "Consultant Recommendation Review" that recorded the members of the IDT who reviewed/participated in the consultant recommendation. There was a notation as to whether an ISPA was generated or not. This approach had generated increased communication between the Dental Department and the QDDPs, which appeared to be helpful. For 12 individuals, copies of correspondence and documents between the Dental Department and the QDDP were submitted and are summarized as follows: ▪ Seven of 12 (58%) included emails from the Dental Department to the QDDP. ▪ Twelve of 12 (100%) included a timeline chart submitted to the QDDP. ▪ Two of 12 (17%) included a formal consultation request to the IDT. ▪ Two of 12 (17%) included a "Consultant Recommendation Review," which included documentation of those that were in attendance during the IDT consultation. ▪ Six of 12 (50%) included a QDDP email response to the Dental Department. ▪ One of 12 (8%) had a consultant report for the IDT to complete, although there was no information as to whether the team or a clinician completed the report. ▪ Seven of 12 (58%) had an ISPA developed and implemented in response to the Dental Department request. ▪ Zero of 12 (0%) returned a copy of the "Consultant Recommendation Review" listing those in attendance during completion of the consultation. ▪ Zero of 12 (0%) of the ISPAs included an attendance roster of participants. The information for these 12 individuals reflected a variety of email communications to the QDDP, and various responses from the QDDP and IDT. It is recommended that this system be formalized through a procedure, and specific documents be tracked to completion. There appeared to be a number of ISPAs created in response to this improved communication. It was not clear whether all documents involving the communication between the two departments had been submitted.	

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		For the time period from 8/1/12 through 2/28/13, there were 91 missed/no show appointments, which were not categorized as refusals for 64 individuals. From this information, the following was documented: ▪ Nine individuals missed two appointments; ▪ Five individuals missed three appointments; ▪ One individual missed four appointments; and ▪ One individual missed five appointments. Reasons for the scheduled appointments that were missed included the following: ▪ Cleaning - 29 appointments; ▪ Annual with cleaning - 17 appointments; ▪ Cleaning with fluoride - 14 appointments; ▪ Annual exam - nine appointments; ▪ Periodic exam - five appointments; ▪ Restorations/dentures – one appointment; ▪ Denture delivery – two appointments; ▪ Desensitization – two appointments; ▪ Toothbrush instruction – one appointment; ▪ MD consultation for medical clearance – one appointment; and ▪ Restorations – nine appointments. Specific residences of individuals missing appointments were not listed on the untitled document. The major reasons identified for missed appointments included the following: ▪ Medical illness of the individual - 46 appointments; ▪ Staffing issues in the residence – 10 appointments; ▪ Individual refused – five appointments; ▪ Behaviors – six appointments; ▪ Individual at school – two appointments; ▪ Individual at work – five appointments; ▪ Dental clinic reasons – four appointments; and ▪ Off campus conflict in the schedule – six appointments. Separately, an untitled and undated document was submitted which listed the date of the missed dental appointment for each individual, the reason for the missed appointment, and whether it was completed. This list identified 68 appointments that had originally been missed (not refused). Twenty-seven of the 68 (40%) were due to illness of the individual. These 68 missed appointments generated 31 additional missed appointments in attempting to complete the original appointment. This was a total of 99 missed appointments. Of these 47 of the 99 (47%) were missed due to illness. There was evidence of correspondence between the Dental Department and the QDDP/IDT for the	

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		individual through a series of email notes. In response to this correspondence, ISPAs were written for zero of these. It was not determined if the action plan created was implemented, and if so, the outcome. It was noted that the missed appointment for one of these was for refusal, indicating that there were still refusals being added to the database for the non-refusal, no-show appointments. The document "CCSSLC Dental Services Department Monthly Trending Report" listed 69 cancelled and 17 no show appointments from August 2012 through February 2013. This was a total of 86 missed appointments for non-refusal reasons. This approached the 91 missed appointments in the prior mentioned document. This was 10 percent of all appointments. From this document, the attendance rate per month from August 2012 through February 2013 ranged from 71.3 percent in January 2013, to 88.7 percent in September 2012. The "Monthly trend Report" through 2/28/13 indicated the attendance rate per residence. Coral Sea attendance was highest, at 91 percent, and Atlantic Unit and Pacific Unit had similar percentage attendance of 77 percent. Homes #515 and #524C had the highest number of cancellations, and Homes #514 and #518 had the most refusals. A document entitled "Individuals identified to have missed dental appointments" listed the missed appointments per month. There were 14 missed appointments for August 2012, five missed appointments for September 2012, nine missed appointments for October 2012, five missed appointments for November 2012, three missed appointments for December 2012, 26 missed appointments for January 2013, and 24 missed appointments for February 2013. There were 69 originally missed appointments that were tracked (removing the repeated missed appointments of the original missed appointments). Of the 69 originally missed appointments, a follow up appointment was documented in 50 cases as follows: ▪ For 24 individuals, the completed appointments occurred from one to 15 days after the missed appointment. ▪ For 15 individuals, the completed appointments occurred from 16 to 30 days after the missed appointment. ▪ For eight individuals, the completed appointment occurred from 31 to 60 days after the missed appointment. ▪ For three individuals, the completed appointment occurred more than 60 days after the missed appointment. ▪ There were 11 missed appointments that had not been rescheduled due to "dorm in isolation." ▪ There were seven missed appointments that had been rescheduled but not	

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		completed, as the appointment date had not yet occurred. ▪ There was one missed appointment for an elective procedure, which had not been rescheduled. For the missed appointments that had not been completed, the following time had elapsed (calculated to 2/28/13, the date of the report): ▪ For nine individuals, the missed appointment, which remained incomplete had been scheduled one to 15 days prior to 2/28/13. ▪ For two individuals, the missed appointment, which remained incomplete had been scheduled 16 to 30 days prior to 2/28/13. ▪ For six individuals, the missed appointment, which remained incomplete had been scheduled 31 to 60 days prior to 2/28/13. ▪ For three individuals, the missed appointment, which remained incomplete had been scheduled more than 60 days prior to 2/28/13. There appeared to be reliable tracking of those with missed appointments. For missed appointments for which the Facility has control (e.g., transportation, staffing in the home, communication between the Dental Department and the home, etc.), the Dental Department is encouraged to make a follow-up appointment within 30 days. The missed appointment rate appeared to have seasonal fluctuations. Comparing quarterly rates for the same time period in prior years might determine whether the Dental Department is continuing to maximize efforts in reducing missed appointments and ensuring early follow-up rescheduling. It might be helpful to subtract conditions that the Dental Department would not be able to alter, and identify a subset of individuals for which additional steps could be helpful. For instance, removing missed appointments for illness of the individual, as well as isolation of dormitories would allow focus on those individuals for which an intervention might be appropriate. The majority of missed appointments were non-refusals, and additional effort in this area to define cases for which the Dental Department could have an impact would be helpful. For new admissions in which there are significant behavioral issues preventing an evaluation, evidence of timely and close collaboration with the psychologist and IDT is necessary to document the Dental Department's activities in resolving issues. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u> Information was submitted concerning use of restraints for dental procedures. For the time period from 8/1/12 through 2/28/13, the dental office did not use mechanical restraints. Seventy-one individuals were provided sedation for dental appointments during this time. Twenty-three of 71 utilized PO sedation and 48 utilized general anesthesia/TIVA. It was noted that the Dental Office documented an "Individual Sedation Report" for each of the 71 (100%), which included the date of the medication (with	

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		history of administration back to 2010), dosage, timing of sedation prior to the appointment, effectiveness of the sedation provided, and the current sedation requirement status. A document entitled "CCSSLC: Percentage of Individuals Utilizing Oral Sedation for Dental Exam and Treatment, between 8/1/2012-2/28/2013" provided the number of total dental appointments requiring oral sedation during this time period. Twenty-four of 824 (3%) completed appointments utilized oral sedation. Oral sedation was used in six of the seven months in this time period. The percentage of appointments using oral sedation was provided per month during this time period. For August 2012, 2.22 percent of appointments used oral sedation. For September 2012, 5.22 percent of appointments used oral sedation. For October 2012, 4.31percent of appointments used oral sedation. For November 2012, 2.83 percent of appointments used oral sedation. For December 2012, no appointments used oral sedation. For January 2013, 3.45 percent of appointments used oral sedation. For February 2013, 1.71 percent of appointments used oral sedation. A document entitled "CCSSLC: Percentage of Individuals Utilizing General Anesthesia/IV Sedation for Dental Exam and Treatment, between 8/1/12-2/28/13" provided the number of total dental appointments requiring TIVA. The total number of appointments utilizing TIVA was 37. The total number of appointments recorded in this document for this time period was 824 (from the "CCSSLC Dental Services Department monthly trending report"). During this time period, 4.5 percent used TIVA. TIVA was utilized five of the seven months, and the percentage use in appointments per month was provided. For August 2012, 6.67 percent of appointments used TIVA. In September 2012, 6.09 percent of appointments utilized TIVA. In October 2012, 6.9 percent of appointments used TIVA. In November 2012, 5.66 percent of appointments used TIVA. No appointments used TIVA in December 2012 and January 2013. In February 2013, 4 percent of appointments used TIVA. Separately, a list of HRC-approved dental restraints was submitted, including the use of oral and IV sedation. The document was entitled "List of HRC approved dental restraints with sedation, including type of sedation, such as PO sedation, IV, or general anesthesia," dated 2/20/13. A total of 115 individuals were listed that required dental sedation. For these 115 individuals, the HRC provided 148 approvals for PO sedation or TIVA sedation. Of these, there were 106 HRC approvals for general anesthesia/TIVA, and 42 HRC approvals for oral sedation. Of the 148 approvals, the approval date appeared to be after the appointment date for four (3%) procedures involving sedation. The Statewide Dental Committee minutes of 9/11/12 documented a new consent	

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		process and HRC approval process. It was clarified that the three doctor consent form could be signed by the dentist anesthesiologist, the contract dentist, and a physician, preferably a community physician or dentist. The consent would then need to go through HRC. It was recommended that all restorative dentistry have this consent. Additionally, all extractions and sedation required HRC approval. *Desensitization* A document entitled "Desensitization Plans Progress Table" was submitted providing information through 11/20/12 concerning desensitization. The following information was included: ▪ One hundred ninety two individuals had been identified for a list to review the need for medical and/or dental desensitization or other plan to reduce the need for restraint. ▪ Of these, 41 (21%) individuals were listed as having desensitization medical and or dental plans. This included 26 (14%) individuals with dental desensitization plans. Separately, 29 (15%) individuals were listed as having medical desensitization plans. ▪ Of these 26 dental desensitization plans, "existing desensitization plan outlines" were submitted for 17. ▪ From this list, 42 of the 192 (22%) individuals were considered not to be candidates for desensitization. However, it was noted that two of these individuals had a dental desensitization plan in place as of 11/20/12. ▪ This document also indicated that 38 (20%) individuals on this list had not been evaluated. ▪ Six (3%) individuals were identified for a dental pilot program. For these six individuals, a copy of the dental desensitization plan was submitted for two individuals and desensitization data sheet templates were submitted for four individuals. A copy of completed "Dental Desensitization (Rehearsal) appointments" was submitted for each of these six individuals. ▪ There was no information concerning 65 individuals (34%) listed in this document. Also submitted were minutes of meetings held to discuss dental desensitization. These meetings were held 1/11/13, 1/18/13, 1/25/13, and 1/28/13. The 1/11/13 meeting confirmed the six individuals identified for desensitization training. On 1/18/13, training on the data collection was to occur, but the members determined that the plans needed task analysis steps and were too nonspecific. The Dental Clinic was to develop a task analysis of clinic activities to develop baseline data for individuals. The 1/25/13 meeting indicated the six individuals would complete task analysis baseline between 1/28/13 and 1/30/13. On 2/1/13, selected committee members were to visit another	

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		SSLC's desensitization program. It was also noted that the Dental and Psychology Departments had different lists of individuals being referred for desensitization plans. A "Dental Anxiety Screening Checklist" was submitted outlining three process steps and 16 task analysis steps. At the 1/28/13 meeting, seven individuals were removed from the list of those referred for desensitization plans. Nine individuals were listed needing further clarification from the teams concerning referral for desensitization plans. Reasons for removal from the list and information concerning clarification was not reflected in the minutes. "A Corrective Action Plan for Desensitization Plans – Section C" was presented at the QA/QI Council. At the January 31, 2013 QA/QI Council, the CAP for desensitization was reviewed. The following was documented to have occurred: ▪ It was stated that the implementation of 23 desensitization plans of both medical and dental had been completed. However, training of dental staff and direct support professionals had not been completed. ▪ A follow up CAP of 3/13 documented that members of the Dental Department visited an SSLC where there was success with dental desensitization. This occurred on 2/1/13. These various meeting minutes provided clarity to the current status of dental desensitization endeavors at CCSSLC. The following is a summary of this information, as of 1/28/13: ▪ Six individuals were identified that would potentially benefit from a dental desensitization plan. ▪ Zero of six (0%) had plans written based on task analysis information. ▪ Zero of six (0%) were implemented. ▪ There was no data to indicate progress in desensitization for these six individuals, nor for the 26 identified as having a dental desensitization plan (0%). ▪ There was no data to indicate any dental desensitization plan was implemented consistently (0%). ▪ Based on analysis, it was not clear if any of the 26 plans had been changed. The initiation of the dental pilot program suggested that these 26 plans were not implemented. ▪ Zero of 26 (0%) individuals were identified as making progress in dental desensitization. ▪ A quarterly dental report did not include analysis/ summarization of progress of the desensitization program.	

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		From this information, it appeared that there had been little progress in this area. Furthermore, the Dental and Psychology Departments could not agree on those who would benefit from desensitization programming. Separately, correspondence between the Dental Department and other departments concerning restraint and sedation use in the dental office was submitted. An email dated 11/7/12 from the Psychology Department stated: "Psychological Services will not be completing medical/dental restraint reduction plans. It is outside of the scope of our practice." It was not clear which department was responsible for developing and implementing desensitization Skill Acquisition Plan as mentioned in the Medical Restraint Plan. The minutes of the 2/7/13 QA/QI Council meeting documented that the IDTs were not addressing refused dental appointments. The Facility submitted copies of minutes from the Restrictive Practice Committee held on the following dates: 5/16/12, 6/13/12, 6/20/12, 6/27/12, 8/8/12, 9/5/12, 9/26/12, 10/24/12, and 1/23/13. During these meetings, 46 dental restraints were listed, for which three questions were generated: ▪ Four of 46 (9%) answered the question: Does the data support the need for restraint? ▪ Two of 46 (4%) answered the question: Documentation correct? ▪ Zero of 46 (0%) answered the question: Desensitization Plan necessary? The minutes did not reflect any discussion or decision concerning dental restraint use, and the purpose of the information listed was not clear. This committee did not provide oversight concerning dental restraint use, nor discuss options concerning reduction of medication or anesthesia used in the Dental Department. Overall, the Facility did not appear to have a system in place to assist the Dental Department in reviewing restraint reduction, including the use of desensitization programs specific to the individuals. <u>Quality Assurance/Improvement Initiatives</u> The QA/QI Department used the audit tool entitled "Settlement Agreement Cross Referenced with ICF-MR Standards for Section Q – Dental Services," revised August 2011. Each month 3.4 percent of the population residing at CCSSLC were sampled. The sample was chosen randomly using computer software. The Dental Department and the QA Nurse completed the monitoring, and the same individuals were reviewed, from which inter-rater reliability could be determined. All 16 components of the monitoring tool were completed. Some components had several subcomponents. A total of 40 audit	

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parameters were reviewed for these 16 components. The number of individuals reviewed by both departments and the inter rater reliability per month were as follows:

Month	Number of records reviewed	Inter rater reliability averaged for the month	Range of inter-rater reliability agreement
September 2012	3	98%	95 - 100%
October 2012	4	91%	80 - 95%
November 2012	0		
December 2012	2	91%	88 - 93%
January 2013	2	90%	85 - 95%
February 2013	2	92%	88 - 95%

Information concerning monitoring was submitted for January 2013. Ten records were reviewed. Compliance scores ranged from 88 percent to 100 percent. Five records had a 100 percent compliance rate.

Two records were reviewed for inter-rater reliability. The following represents the compliance scores for these two records by both the Dental and QA Departments:

Record	Dental Department compliance %	QA Department compliance %
#1	90	80
#2	82	100

Indicators were listed that provided guidance for areas needing improvement:

- (Q01.11c.) Developed strategies to overcome the individual's refusals to participate in dental appointments.
- (Q01.11d) Implemented the strategies that were developed.
- (Q01.13) If the individual uses pre-sedation or restraints, there is a desensitization program and/or strategies to reduce the need for the use of pre-sedation and/or restraints in place.
- (Q01.14a) Pre-sedation plan/strategies are being implemented.

For these two records, the questions for which the auditors did not agree were reviewed. There was only one parameter for which there was disagreement: (Q01.11.d) Implemented the strategies that were developed.

The Dental Department provided a periodic review of dental services at the QA/QI Council.

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

1. A system should be put in place to minimize the time from exam completion to report completion as other departments rely on timely reports. (Section Q.1)
2. The Dental Department should provide updated training rosters and percentage of total staff trained for the hands on training, classroom training/I-learn video training, etc., on a quarterly basis. (Section Q.1)
3. The Dental Department should provide further review, training, and assistance to those who are self-brushing, but with worsening oral hygiene rating scores. (Section Q.1)
4. Communication with the QDDP and IDTs should be formalized, and specific documents should be tracked to completion. (Section Q.2)
5. The Facility should develop and implement a system to review dental restraint reduction, including the use of desensitization programs specific to individuals. (Section Q.2)
6. The Dental Department should ensure that all the various dental services provided are reflected in policies and procedures. (Section Q.2)

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: Communication Comprehensive assessment; Update and Assessment of Current Status; ISP and ISPAs for past year; Positive Behavior Support Plan; skill acquisition programs related to communication and supporting documentation for implementation (indirect supports); direct SLP therapy intervention plans and supporting documentation such as IPNs, monthly reviews by SLP, AAC programs, and supporting documentation for implementation of indirect supports; individual-specific communication monitoring for past six months; and evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect), for 19 individuals who had communication deficits, alternative and augmentative communication (AAC) system(s), and/or received direct communication supports, including: Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #297, Individual #137, Individual #221, Individual #268, Individual #367, Individual #201, Individual #58, Individual #348, Individual #333, Individual #290, Individual #321, Individual #14, and Individual #38; o Policy and procedures addressing the provision of speech and/or communication services and supports, including changes since the Monitoring Team's last visit; o Continuing education and other training completed by SLPs with certificates of completion, since the Monitoring Team's last visit; o List of current SLP and audiology staff along with corresponding caseloads, and CVs for newly hired SLPs; o List of individuals with AAC devices; o Communication Master Plan List; o AAC Screening forms; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes; o Tracking Log of SLP assessments completed since Monitoring Team's last review; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators; o Copies of blank communication competency-based performance check-off sheets for new employees; o Inter-rater reliability compliance scores and corresponding audits; o List of individuals receiving direct speech services and focus of intervention; o List of individuals with behavioral issues and coexisting severe language deficits, and risk level/status for challenging behavior; o List of individuals with PBSPs and replacement behaviors related to communication; o Minutes for Communication committee meetings held since the Monitoring Team's last review;

	○ Minutes for Speech Department meetings held since the Monitoring Team's last review; ○ List of all general common area communication devices; ○ OT/PT Assessments, ISPs, and PNMPs for four individuals most recently assessed by an SLP for whom AAC device was recommended, including: Individual #193, Individual #184, Individual #440, and Individual #344; ○ Blank communication competency-based performance check-off for individual-specific communication programs; ○ External consultant reports since last review; ○ Completed audits of SLP documentation; ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review; and ○ American Speech Hearing Association (ASHA) certification for SLPs. ▪ **Interviews with:** ○ Dr. Angela Roberts, Director of Habilitation Therapy; ○ Nancee Dixon, SLP/CCC, Section R Lead; ○ Melissa Grothe, SLP/CCC; and ○ Cheryl Bost, SLP/CCC. ▪ **Observations of:** ○ Individuals in Coral Sea, Pacific, and Atlantic residences.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 3/18/13. In its Self-Assessment, for each subsection, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section R, in conducting its self-assessment: ▪ The Facility used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, various monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/audit tools, inter-rater reliability data, as well as interviews with the Director of HT, Section R Lead, and Program Compliance Monitor: ○ The monitoring/audit tool the Facility used to conduct its self-assessment included: the State Section R Monitoring Tool and various Facility-developed audit tools to assess compliance with indicators presented in Monitoring Team's reports. The Director of HT stated that the current Monitoring Tool did not accurately assess the Facility's current compliance status in each of the sections. The Director of HT wanted to revise the monitoring tool to incorporate the indicators/metrics from the Monitoring Team's report that more accurately assessed the status of compliance within each of the sections. ○ The Monitoring Team agreed that the current unrevised Monitoring Tool for Section R did not include adequate indicators to allow the Facility to determine the current state of compliance with Section R. However, the data presented in the self-assessment reflected the completion of activities/audits completed outside of the scope of the Monitoring Tool for Section R. These audits provided a positive move forward in monitoring compliance with Section R. The Facility is encouraged to review the Monitoring Team's report to

	identify additional indicators/metrics that are relevant to making compliance determinations. The development of the template for the presentation of data was a very promising step forward in aligning the items to be monitored with the Monitoring Team's indicators/metrics. o The monitoring tool did include adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample(s) sizes. o The monitoring/audit tool did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. On a positive note, the Director of HT and the PCM continued to revise the monitoring tool guidelines. o The following staff/positions were responsible for completing the audit tool: The Director of HT and the PCM. o Adequate inter-rater reliability had been established between the Director of HT and the PCM. ▪ The Facility used some other relevant data sources, including, for example, a communication assessment audit tool which incorporated essential components from the previous Monitoring Report and the HT department database. ▪ The Facility presented some data in a meaningful/useful way, but more work was needed. Specifically, the Facility's Self-Assessment: o Did present findings consistently based on specific, measurable indicators. o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in noncompliance with all subsections of Section R. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. However, for these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings.
	Summary of Monitor's Assessment: The Facility had seven SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC. Four communication policies had been developed, but they were missing essential components. Individuals newly admitted to CCSSLC had communication assessments completed within 30 days. Individuals' communication assessments were missing some essential components. Communication supports and interventions were not integrated in individuals' ISPs. Observations of individuals with AAC systems revealed they were not using the systems. Staff did not understand how to engage individuals with the systems. The most significant finding was the systems were not functional for the individuals. Individuals who received direct SL therapy intervention did not have plans initiated in a timely manner, assessments did not provide a rationale for direct therapy, there was an absence of integration in the ISP, and progress notes did not include essential components. Individual-specific

	training and performance check-offs had not been developed and implemented for individuals with AAC systems with the exception of one individual. The Facility did not have a policy for monitoring communication supports. Individuals with AAC systems had not been monitored using the Compliance Monitoring form. In addition, the Facility had identified that the monitoring data it was collecting was not reliable.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Samples for Section R:** ▪ **Sample R.1:** Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months, including the following ten individuals: Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #201, Individual #14, Individual #38, and Individual #297. ▪ **Sample R.2:** Four individuals receiving direct speech interventions including: Individual #251, Individual #110, Individual #136, and Individual #67; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits including: Individual #251, Individual #136, Individual #297, Individual #367, Individual #58, Individual #348, Individual #333, and Individual #290; ▪ **Sample R.4**: Eight individuals with AAC devices including: Individual #145, Individual #297, Individual #137, Individual #251, Individual #110, Individual #221, Individual #268, and Individual #367. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section of the report addresses compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **<u>Staffing</u>** The Facility did not use a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC. A "reasonable process" to determine an adequate number of SLPs would include an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities would include, but not be limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs.	Noncompliance

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		The Facility did not indicate what would be an appropriate caseload for SLPs. The Facility should complete an assessment to include consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. In addition, an adequate SLP caseload should be related to successful implementation of the requirements of Sections R.1 through R.4. The Facility did have SLPs to fill the seven allocated positions. **Qualifications:** ▪ Seven of seven SLPs (100%) were licensed to practice in the state of Texas. ▪ Six of six SLPs (100%) had evidence of ASHA certification. The seventh SLP did not hold the Competency of Clinical Certification (CCC) issued by ASHA, because she was "grandfathered" into the profession of Speech Language Pathology in January 1986. **Continuing Education** Four of seven SLPs staff (57%) had completed continuing education directly related to communication and transferrable to the population served. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. The continuing education the clinicians attended included the following topics: ▪ Autism, Asperger's, Sensory ADHD Seminar (7/18/12); ▪ Evidence-Based Practice for AAC Evaluations: Building the Meaning Behind the Acronyms (8/1/12 to 8/2/12); ▪ Dementia Care (8/14/12); ▪ Annual Habilitation Therapies Conference (9/20/12 to 9/21/12); ▪ Practical Activities for Milestone Development (11/8/12); and ▪ Nothing by Mouth (NPO) Recommendations from the Modified Barium Swallow Study (MBSS) (1/26/13). **Facility Policy** During the week of the onsite review, four SLP policies were approved at the 4/4/13 QA/QI meeting, including: ▪ Policy R.1, Communication Services: Roles and Responsibilities of Speech-Language Pathologist; ▪ Policy R.2, Communication Services: Process for Servicing Individuals at High Risk (with Challenging Behaviors); ▪ Policy R.3, Communication Services: Assessments; and ▪ Policy R.4, Communication Services: Referral Criteria. The Facility did not have a comprehensive communication policy, because the policies did not include the following elements:	

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		▪ A process for effectiveness monitoring by the SLP; and ▪ Methods of tracking progress and documentation standards related to direct intervention plans. The essential components of a monitoring policy are addressed with regard to Section R.4. The Facility's policies did include the following elements: ▪ Roles and responsibilities of the SLPs; ▪ An outline of an assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission); ▪ Timelines for completion of comprehensive assessments (within 30 days of identification via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT); and ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment. In summary, the Facility had seven SLPs, but there was not a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC. Four of the seven SLPs had completed continuing education. Four communication policies had been developed, but there were missing essential components. The Facility remained out of compliance with this section.	
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.	**Communication Assessments Provided** Three of three individuals newly admitted since the last review (i.e., Individual #338, Individual #59, and Individual #39) (100%) received a communication screening or assessment within 30 days of admission or readmission. **Communication Assessment** Based on review of the individuals in Sample R.1, the comprehensiveness of the communication assessments were as follows: ▪ Ten of 10 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Five of 10 individuals' SL assessments (i.e., Individual #145, Individual #315, Individual #67, Individual #201, and Individual #38) (50%) were dated as completed at least 10 working days prior to the annual ISP; ▪ Nine of 10 individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual	Noncompliance

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		#201, Individual #38, and Individual #297) (90%) included diagnoses and relevance of impact on communication; ▪ Eight of 10 individuals' SL assessments (i.e., Individual #251, Individual #315, Individual #110, Individual #67, Individual #201, Individual #14, Individual #38, and Individual #297) (80%) included individual preferences, strengths, and needs. Preferences listed were derived from the Preferences and Strengths Inventory (or other relevant document) developed by the individual's team, as well as information obtained from staff interviews; ▪ One of 10 individuals' SL assessments (Individual #38) (10%) included medical history and relevance to communication. The medical history refers to medical conditions that would impact the provision of SLP communication supports and services; ▪ Nine of nine individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication. Individual #14 did not take any medication; ▪ Nine of 10 individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #201, Individual #14, and Individual #297) (90%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Two of 10 individuals' SL assessments (i.e., Individual #14 and Individual #38) (20%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Ten of 10 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); ▪ One of nine individuals' SL assessments (11%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. Individual #14 communicated verbally; ▪ Eight of nine individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #38, and Individual #297) (88%) included discussion of the expansion of the individuals' current abilities. For these individuals, the SLP assessment discussed how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs; ▪ Eight of nine individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #38, and Individual #297) (88%) provided a discussion of the individuals' potential to develop new communication skills. For these individuals, the SLP assessment provided an analysis of the individual's current communication	

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		deficits with suggestions for direct interventions and/or skill acquisition programs; ▪ None of nine individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings. The SLP assessment should present clinical data to support the effectiveness of the individual's current supports. This clinical data should include the results of individual-specific compliance and effectiveness monitoring; ▪ One of the eight individuals' SL assessments (i.e., Individual #38) (13%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. Individual #14 had adequate verbal communication skills and, therefore was not included in this calculation. Some of the examples of the problems found with the assessments included: o Individual #251's communication assessment indicated she received a communication voice output device in 2010. The Monitoring Team has had the opportunity to observe Individual #251 on multiple occasions. Unfortunately, in most of these observations, she did not have her device with her in her home and/or at work. The Monitoring Team would ask staff to set up her device, but her communication partners were not familiar with her device and/or were not able to prompt her to use the device. Furthermore, Individual #251 was not able to communicate using her device with the Monitoring Team. Consequently, the Monitoring Team would have expected her AAC assessment to assess other options beyond her Conversa to enhance her communication ability. o The communication history section of Individual #145's communication assessment noted: "previous records indicate that [Individual #145] was not receptive to Augmentative/Alternative Communication Devices." The current assessment acknowledged she was able to activate a voice device. However, the assessment did not provide clinical justification and rationale for the future use of an AAC and/or environmental control device. o Individual #110's communication assessment noted: "it is suggested that trials begin again to determine a means of communication that can expand her current modes of communication." It was unclear why the assessment did not assess her abilities by testing her skill with various AAC and/or EC devices. o Individual #297's assessment provided information on her refusal to use her current device. The assessment should have assessed her potentials and/or other abilities with different AAC devices. Again, the Monitoring Team has interacted with Individual #297 on multiple	

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		occasions. Individual #297 has a strong need to be able to communicate effectively with her communication partners. Her familiar staff might be able to understand her, but other communication partners not familiar with her will have difficulty in understanding her, which increases her frustration. Her assessment did not adequately assess other AAC options for her; ▪ None of 10 individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year. The SLP assessment should provide an overview of an individual's health status over the past year. The therapist should discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status; ▪ Two of nine individuals' SL assessments (i.e., Individual #201 and Individual #297) (22%) gave a comparative analysis of current communication function with previous assessments. The SLP assessment should provide an overview of the past assessment results with the current assessment data for communication function. The assessment analysis should discuss if the individual's communication performance has remained the same, has improved, and/or has regressed; ▪ Eight of nine individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #38, and Individual #297) (88%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ One of nine individuals' SL assessment (i.e., Individual #38) (11%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Ten of 10 individuals' SL assessments (100%) had a reassessment schedule; ▪ Four of the nine individuals' SL assessments (i.e., Individual #251, Individual #67, Individual #201, and Individual #297) (44%) supplied a monitoring schedule. The SLP assessment should discuss monitoring results from the previous year and recommend the implementation of a monitoring schedule for the upcoming year. The therapist should describe the monitoring form(s) to be utilized; ▪ Eight of nine individuals' SL assessments (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #136, Individual #67, Individual #201, and Individual #38) (88%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. For these individuals, the SLP assessment analysis section provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs; ▪ Ten of 10 individuals' SL assessments (100%) made a recommendation about	

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		the appropriateness for community transition. As required by State Office, for these individuals, therapists included their opinions about whether or not the individual could effectively be supported in the community. If the therapist believed the individual could not be supported in the community, the therapist identified what supports the individual needs were missing in the community; and ▪ None of the nine individuals' SL assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessment should provide suggestions for direct support professionals and other IDT members, as appropriate, to implement an individual's indirect programs (i.e., PNMP) and reinforce skills being learned in direct therapy interventions. **SLP and Psychology Collaboration:** Based on review of individuals in Sample R.3 with Positive Behavior Support Plans the following was noted: ▪ Two of eight individuals' communication assessments and PBSPs reviewed (i.e., Individual #297 and Individual #367) (25%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. There should be a correlation between the recommendations made in the assessment with the replacement behaviors or other strategies in the PBSP. If not, there should be an explanation provided by the SLP for why these strategies would not be used as replacement behaviors or other strategies in the individual's PBSP. ▪ Four of eight individuals' communication assessments (i.e., Individual #251, Individual #136, Individual #297, and Individual #367) reviewed (50%) contained evidence of review of the PBSP by the SLP. The assessment should contain a discussion of the collaboration between the SLP and the psychologist in the development of communication strategies for replacement behaviors or other strategies related to communication. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 9/7/12 to 1/30/13, participation by a SLP was noted in none of the 27 meetings (0%). SLPs and psychologists should collaborate on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Since the last review, the Director of HT reported that SLPs attending the Positive Behavior Support Committee meetings had not been productive. The SLPs were directed to work one-on-one with psychologists to collaborate on the integration of an individual's functional communication abilities into a PBSP. In interviews conducted with the SLPs, this was resulting in a more productive collaborative approach. In addition, this collaboration	

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		was present in some of the assessments reviewed. In summary, individuals newly admitted to CCSSLC had communication assessments completed within 30 days. Individuals' communication assessments continued to improve, but there were missing some essential components. SLPs were not collaborating with psychologists and/or were not documenting collaboration. The Facility remained out of compliance with this section.	
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.	**Integration of Communication in the ISP** Based on review of the ISPs for nine individuals in Sample R.1 (i.e., Individual #14 communicated verbally, so his ISP was not reviewed for this section), the following was noted: ▪ The Pre-ISP Meeting indicated that: o For six of the nine individuals (i.e., Individual #145, Individual #251, Individual #315, Individual #110, Individual #67, and Individual #297) in Sample R.1 the attendance of the SLP was required. For four of these six individuals' ISPs reviewed (i.e., Individual #145, Individual #251, Individual #110, and Individual #297) (67%), an SLP attended the annual ISP planning meeting. o Attendance by a SLP at the annual ISP meeting was not required for three individuals (i.e., Individual #136, Individual #201, and Individual #38). However, no justification for Individual #38 was provided for the team's recommendation that the SLP not be in attendance. The justification for Individual #201 and Individual #136's SLP not to attend was "information can be obtained from assessment." However, a review of these individuals' assessments indicated that a SLP should attend the annual ISP. For example, Individual #136 had an AAC system. The expertise of the SLP would be helpful in assisting IDT members to understand how to imbed his AAC system in daily activities. Per current State Office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, team will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. ▪ Five of nine ISPs reviewed (i.e., Individual #145, Individual #315, Individual #110, Individual #67, and Individual #38) (56%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. These ISPs contained information on how the individual communicates and how staff can improve communication with the individual. The type of AAC and/or communication supports (including, but not limited to, the Communication Dictionary and	Noncompliance

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		strategies for staff use) was identified. ▪ None of nine ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. ISPs should contain information on how communication strategies can be integrated throughout the day and throughout the other selected goals. Information should be consistent with the communication assessment and provide detailed descriptions to ensure staff consistency. ▪ One of nine ISPs reviewed (i.e., Individual #67) (11%) contained skill acquisition programs to promote functional communication. As appropriate to the individual's needs, ISPs should contain a program (direct or indirect) that is aimed at improving functional communication. Individuals with AAC systems should have skill acquisition programs and/or other specific staff supports to promote the generalization of the use of the AAC system in multiple environments. ▪ None of nine ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. The ISPs should provide information on status of goals/programs and recommendations for the future. This information should include data as appropriate. **Development and Implementation of Functional Individual-Specific Assistive Communication Systems** Observations were conducted in the homes of six individuals (i.e., Individual #145, Individual #297, Individual #137, Individual #251, Individual # 110, and Individual #136) with AAC systems in Sample R.4. Findings included the following: ▪ Four of six observations (i.e., Individual #145, Individual #137, Individual #110 and Individual #136) found individuals' AAC devices present in each observed setting and readily available to the individual. However, these systems were not functional for the individual to interact with a communication partner. For example, Individual #136 could not identify icons and/or answer simple questions using his communication board. In addition, there were no established measurable outcomes developed for these systems to support interaction with a communication partner. ▪ AAC systems for none of six individuals (0%) were noted to be in use in each observed setting. ▪ AAC systems for six of six individuals (100%) were portable. ▪ AAC systems for none of the six individuals (0%) were functional. As noted above, these systems did not support a functional way for the individual to communicate. ▪ For none of six individuals (0%), staff instructions/skill acquisition plans related to the AAC system were available. Staff were not able to show the Monitoring	

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		Team staff instructions and/or skill acquisition programs for the systems. **General Use AAC Devices:** The Facility indicated the intent of all common area devices was to promote communication skills and encourage incidental learning in the context of daily living activities. The Facility provided a communication equipment list that identified shared AAC devices that included the location and type of device. The Monitoring Team observed the presence of general-use AAC devices during observations of the five individuals in their residences and workshops. These devices included staff instructions. However, the Monitoring Team did not observe staff and/or individuals utilizing these generic devices. **Direct Communication Interventions** Seven individuals were receiving direct speech interventions. Sample R.2 included four of these seven individuals. Review of the individuals' records in Sample R.2 records revealed the following: ▪ One of four individual's direct intervention plans (i.e., Individual #67) (25%) was implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For none of four individuals' records (0%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. The SLP assessments did not include an analysis of assessment data to provide justification for initiation of a direct therapy intervention. ▪ For none of four individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of four individuals (0%), information was present regarding whether the individual showed progress with the stated goal. The therapist should have reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). ▪ For none of four individuals (0%), a description was found of the benefit of the device and/or goal to the individual. The therapist should have reported on a monthly basis through the provision of clinical data how the goal was supporting communication for the individual in their daily activities. ▪ For none of four individuals (0%), a report was found regarding the consistency of implementation. The therapist should have reported on a monthly basis the frequency of implementation of the recommended plan and/or program implementation. ▪ For none of four individuals (0%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Based on the therapist's monthly data, if a lack of	

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		progress is noted, team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT should revise these interventions. **Competency-Based Training and Performance Check-offs:** Competency-based training and performance check-offs for communication were addressed with regard to Section O.5 for new employees and veteran staff. **Individual-Specific Competency-Based Training** For one of the eight individuals (i.e., Individual #268) (0%) in Sample R.4 with AAC devices, documentation showed staff had received individual-specific training. Seven staff working with Individual #268 had completed an individual-specific performance check-off. No data was presented to identify the total number of staff that would require individual-specific training for his AAC system. Consequently, the Monitoring Team could not determine compliance with the provision of individual-specific competency training and performance check-offs for Individual #268. To meet the standard of competency-based training, the performance check-offs should include a demonstration component for individual-specific communication programs. The Facility did not have a process to validate that staff responsible for training other staff were competent to assess other staff's competency. Staff responsible for training other staff should have the requisite skills to train staff and complete performance checklists. In summary, the integration of communication supports and interventions were not integrated into individuals' ISPs. Observations of individuals with AAC systems revealed the systems were not being used. Staff did not understand how to engage an individual with the systems. The most significant finding was the systems were not functional for the individuals. Individuals who received direct SL therapy intervention did not have plans initiated in a timely manner, assessments did not provide a rationale for direct therapy, there was an absence of integration in the ISP, and progress notes did not include essential components. Individual-specific training and performance check-offs had not been developed and implemented for individuals with AAC systems with the exception of one individual. The Facility remained out of compliance with this section.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and	**Monitoring System** A Facility policy and/or procedures did not exist that described the monitoring system for communication provision of the ISP for individuals who would benefit from AAC. The Facility policy and/or procedures should include the following essential components	Noncompliance

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	implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	related to monitoring: ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the working condition of communication adaptive equipment; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels; ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). **<u>Monitoring of Implementation of Communication Supports</u>** The last three months of Compliance Monitoring forms for implementation of communication supports for individuals in Sample R.1 were reviewed, and the following was found: ▪ For eight of the eight individuals with AAC systems (100%), Monthly Person-Specific PNMP Check Sheets had been completed. ▪ However, none of the eight individuals' staff (0%) had been monitored with the Compliance Monitoring form. For additional information on the status of expanding the scope for compliance monitoring, please refer to Section O.6. In summary, the Facility did not have a policy for monitoring communication supports. As discussed with regard to Section O.6, the Facility had identified that the monitoring data it was collecting was not reliable. In addition, individuals with AAC systems had not been monitored using the Compliance Monitoring form. The Facility remained out of compliance with this section.	

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

1. The Facility should complete an analysis to determine an appropriate caseload for SLPs at CCSSLC, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. (Section R.1)
2. The Facility should revise its local Communication Services policy and/or procedure to incorporate the following essential components:
    a. A process for effectiveness monitoring by the SLP;
    b. Methods of tracking progress and documentation standards related to intervention plans; and
    c. Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as problem resolution. (Section R.1)
3. The Facility should review the revised SL assessment template and content guidelines to ensure the essential components for SL comprehensive assessments are addressed. The SLPs should consider each of these elements as they complete assessments to ensure

assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audits should assess these elements. (Section R.2)

4. The Facility should ensure communication assessments and PBSPs address the connection between the PBSP and the recommendations contained in the communication assessment, as well as contain evidence of review of the PBSP by the SLP. (Section R.2)
5. Individuals' ISPs should include: attendance by a SLP for individuals with communication needs unless the team provides adequate justification; the type of AAC device/system and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary, and identification of necessary changes as appropriate; a description of how the individual communicates, including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. (Section R.3)
6. The Facility's monitoring policy for communication devices should include:
    a. Monitoring for the presence of communication adaptive equipment or other AAC supports/materials;
    b. Monitoring for the working condition of communication adaptive equipment;
    c. Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work);
    d. The frequency of monitoring for individuals within the established Master Communication Plan priority levels;
    e. The process for identification, training, and validation for monitors;
    f. The process of inter-rater reliability; and
    g. A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). (Section R.4)

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 Section S Presentation Book completed by Kimberly Benedict, Director of Day Programs; o Section S – Monthly Benchmark Report Section S completed by Kimberly Benedict, Director of Day Programs, dated 2/15/12; o Listing of Individuals with most recent ISP meeting, date ISP completed, date ISP filed, and previous ISP date (TX-CC-1301-I.6); o For Section S.1, Skill Acquisition Plans (SAPs), SAP data and monthly Integrated Progress Notes for the last two months, as available, for: Individual #255, Individual #172, Individual #147, Individual #237, Individual #68, Individual #21, Individual #167, Individual #42, Individual #312, Individual #141, Individual #159, and Individual #263; o For Section S.1, Dental Desensitization Plans, as available, for: Individual #181, Individual #128, Individual #363, Individual #65, Individual #285, Individual #147, Individual #87, Individual #4, Individual #215, Individual #9, Individual #211, Individual #22, Individual #334, Individual #273, Individual #70, Individual #15, Individual #303, and Individual #222; o For Section S.1, Medical Desensitization Plans, as available, for: Individual #58, Individual #215, Individual #235, Individual #4, Individual #176, Individual #8, Individual #310, Individual #128, Individual #198, Individual #363, Individual #87, and Individual #156; o Facility Engagement Report, August 2012 to January 2013; o For Section S.2, Preferences and Strengths Inventory (PSI), Functional Skills Assessment (FSA), Individual Support Plan, pre-ISP Addendums, as available, for: Individual #255, Individual #172, Individual #147, Individual #237, Individual #68, Individual #21, Individual #167, Individual #42, Individual #312, Individual #141, Individual #159, and Individual #263; o For Section S.2, Vocational Assessments, as provided, for: Individual #4, Individual #31, Individual #55, Individual #69, Individual #157, Individual #255, Individual #237, individual #62, Individual #297, and Individual #158; o Summary documentation - Vocational Assessments Completed, from 5/1/12 to 2/1/13; o Picture Exchange Communication System (PECS) - Implementation Checklists for PECS and/or Implementation Checklist for Structure Work Systems, as available and provided, for: Individual #155, Individual #60, Individual #198, Individual #371, and Individual #147; and o For Section S.3, Skill Acquisition Plans, Preferences and Strengths Inventory, Functional Skills Assessment, Individual Support Plan, pre-ISP Addendums, monthly data sheets for last two months, and ISP Monthly Reviews for last two months, as available, for: Individual #255, Individual #172, Individual #147, Individual #237, Individual #68, Individual #21, Individual #167, Individual #42, Individual #312, Individual #141,

Individual #159, and Individual #263.

- **Interviews and Meetings with**:
  - Section S review with Kimberly Benedict, Day Program Director, on 4/3/13 and 4/4/13;
  - Meeting with Kristina Sheets, Director of Residential Programming, on 4/3/13;
  - Meeting with QA/QI and Section K Program Compliance Monitors, including Judy Sutton, M.S., LPC, BCBA, Chief Psychologist and Karen Ryder, QA/Program Compliance Monitor, on 4/4/13;
  - Meeting with QA/QI and Section S Program Compliance Monitors, including Kimberly Benedict, Day Program Director, and Araceli Matehala, Program Compliance Monitor, on 4/4/13; and
  - Coordinators and Supervisors of Day Treatment, Active Treatment, Vocational, and Educational Staff, on 4/4/13.
- **Observations**:
  - Observation and discussion at the Restrictive Practices Committee meeting, on 4/1/13;
  - Observation and discussion at the Psychology Department meeting, on 4/2/13;
  - Observation and discussion at the BSC follow-up meeting, on 4/2/13;
  - Observation and discussion at the Skill Acquisition Committee meeting, on 4/2/13;
  - Observation and discussion at the BSC Meeting, on 4/3/13;
  - Observation and discussion at the Vocational Department meeting, on 4/4/13;
  - Observation of PBSP training at Porpoise, on 4/4/13;
  - Observation of Skill Plan Integrity checks at Ribbonfish 1 (524A) and the Outer Reef on 4/4/13;
  - On-site direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites:
    - Apartment 522A (Kingfish 1), on 4/1/13;
    - Apartment 522B (Kingfish 2), on 4/1/13;
    - Apartment 522C (Kingfish 3), on 4/1/13;
    - Apartment 522D (Kingfish 4), on 4/1/13;
    - Apartment 524A (Ribbonfish 1), on 4/2/13 and 4/4/13;
    - Apartment 524B (Ribbonfish 2), on 4/2/13;
    - Apartment 524C (Ribbonfish 3), on 4/2/13 and 4/3/13;
    - Apartment 524D (Ribbonfish 4), on 4/2/13 and 4/3/13;
    - Apartment 514 (Dolphin), on 4/3/13;
    - Apartment 518 (Porpoise), on 4/3/13;
    - Apartment 515 (Sea Horse), on 4/3/13; and,
    - Outer Reef, on 4/4/13.

Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	For Section S, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the CCSSLC Section S – Habilitation, Training, Education, and Skill Acquisition Programs Tool, revised 9/15/12, the CCSSLC Skill Acquisition Plan rubric and the CCSSLC Integrity Check for Skill Acquisition Plan rubric. Summary data of inter-rater reliability scores based on Section S program monitoring tools from January and February 2013 were provided. This included data reflective of the comprehensive review for two individuals per month using the monitoring tool. In addition, summary data of compliance scores based on the skill acquisition plan rubric from September 2012 through March 2013 were provided. In addition, summary data of inter-rater reliability scores as well as examples of completed rubrics (for four individuals), based the skill acquisition plan rubric, were provided for March 2013. Verbal reports at the time of the Monitoring Team's visit indicated that the Section S monitoring tool was completed on two sample individuals per month and compliance (and inter-rater reliability) for each provision of the Settlement Agreement was determined. Summary data of these efforts was reported in the Program Compliance Monitor's quarterly report as well as the Day Program Director's monthly and quarterly reports. Discussions during the onsite visit reflected a very collaborative and effective monitoring process. Potential future efforts to expand the use of the Section S monitoring tool (i.e., examining the potential integration of Section S and F tools) were discussed as well. ▪ Used other relevant data sources. o The current Self-Assessment also contained other types of data from available sources. This included data obtained from completed SAP rubrics (completed by the Skill Acquisition Review Committee as well as sampled reviews), scores on engagement tools and integrity checklists (from NEO as well as follow-up probes), and review of sampled ISPs. In addition, data was obtained from the review of sampled assessments (e.g., educational and training assessments, functional skills assessments, personal focus assessments, and vocational assessments) and from the database used to track completion dates as well as community outings, classroom and vocational attendance, and employment/employer data. ▪ The Facility consistently presented findings based on specific, measurable indicators. ▪ The Facility measured the quality as well as presence of some items. ▪ The Facility did not rate itself as being in compliance with any of the sections of Section S. This was consistent with the Monitoring Team's current findings.
	Summary of Monitor's Assessment: Progress was noted in many areas of Section S of the Settlement Agreement. However, concerns remained across the three provisions. Some progress was noted in the development of skill acquisition plans and evidence of substantial training

	to support better development and implementation of programming was evident. However, several elements critical to skill acquisition within the SAPs, including those targeting medical and dental desensitization, remained inadequate. Efforts to improve classroom and vocational attendance were also observed. In addition, efforts to improve on- and off-campus employment opportunities through vocational tours and job explorations were noted. Unfortunately, although estimates of engagement identified by the Monitoring Team appeared improved, the level was still not judged as adequate. Collection of data targeting these outcomes was likely to improve progress monitoring and corrective responding, when necessary, over time. Efforts directed at supporting improvement in annual assessments in the areas of living, working, and leisure activities were noted. However, concerns remained regarding the adequacy and/or timeliness of the assessments. The Facility's attention to supporting better data collection of skill programming was also noted, but these improvements did not appear to translate to improved monthly progress monitoring.

#	Summary of Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Continued effort and progress in some areas of habilitation training and services was noted, including improvement in some elements of the skill acquisition plans. However, the development of fully adequate SAPs, including those used in medical and dental desensitization, remained problematic. Provided documentation evidenced the completion of a new "local" policy for Section S - Habilitation, Training, Education, and Skill Acquisition, dated 1/17/13, targeting the process for developing, reviewing, and monitoring the implementation of skill acquisition plans. This new policy provided a brief overview of the general process related to skill acquisition. In addition, new "local" Section S policies were also evident with regard to Water Activity Safety Assessments, dated 1/18/13; Engagement, dated 1/18/13; Education and Training Assessments, dated 1/17/13; and Ensuring Opportunities for Day and Vocational Programming Away from Home, dated 1/17/13. Staff anticipated that one or more of these local policies might likely be replaced with policies developed at the State Office level in the future. In an effort to review the adequacy of the most recently developed SAPs, a sample of 12 individuals with ISP meetings held within the last six months (10/1/12 to 3/31/13) was selected for review. In an effort to ensure a representative sample across residential programs, one individual who met this criterion was selected from each residential program. More specifically, the sample included individuals from 12 different residential programs based on the provided summary listing of most recent ISP dates (i.e., TX-CC-1301-I.6). According to this documentation, approximately 77 individuals had ISP meetings during the last six months. Consequently, the current sample reflected	Noncompliance

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		approximately 16 percent of those individuals. Overall, a total of 64 SAPs provided for 12 individuals were briefly reviewed, and it was found that approximately five (range of two to seven) were developed, on average, for each individual sampled. It was noted that, of the 12 individuals reviewed, 12 (100%) had at least one SAP targeting completion in a community setting, 12 (100%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings, and 12 (100%) had at least one SAP targeting completion in the residence. In an effort to more closely examine the quality of current skill plans, one SAP was randomly selected from each of the 12 individuals sampled and reviewed. These were as follows: ▪ The SAP for Individual #255 targeting the "Offensive Cycle" (dated 11/5/12); ▪ The SAP for Individual #172 targeting serving size (dated 12/28/12); ▪ The SAP for Individual #147 targeting dressing (dated 11/5/12); ▪ The SAP for Individual #237 targeting healthy food choices (dated 11/2/12); ▪ The SAP for Individual #68 targeting choice making (dated 1/29/13); ▪ The SAP for Individual #21 targeting community awareness (dated 1/4/13); ▪ The SAP for Individual #167 targeting hand cream (dated 1/15/13); ▪ The SAP for Individual #42 targeting medication (dated 10/25/12); ▪ The SAP for Individual #312 targeting healthy choices (dated 2/6/13); ▪ The SAP for Individual #141 targeting seatbelt use (dated 12/24/12); ▪ The SAP for Individual #159 targeting dental care (dated 11/12/12); and ▪ The SAP for Individual #263 targeting paper shredding (dated 11/14/12). Of the 12 SAPs reviewed, the following was noted: ▪ Zero (0%) had adequate behavioral objectives. All of the behavioral objectives targeted demonstration of all steps of the task analysis, but also referenced a certain specific step of the task analysis in parentheses within the objective (e.g., "… [Individual 263] will improve his paper shredding skills by demonstrating task analysis steps 1-4 (implemented at step 2), for 3 out of 4 trials per month for 3 consecutive months"). It was unclear to the Monitoring Team how this objective would ultimately be evaluated, that is, targeting just step 2 or steps 1-4. In addition, one behavioral objective appeared to be unrealistic (Individual #21); ▪ Seven (58%) had adequate operationally defined target behaviors. The exceptions were individuals with definitions with vague terms (i.e., Individual #255, Individual #147, Individual #68, and Individual #312) or included a definition that was integrated within the behavioral objective (Individual #42); ▪ Three (25%) had an adequate task analysis. Those SAPs with inadequate task analysis included those SAPs that identified only staff responses (i.e., Individual #255, Individual #237, and Individual #21) or identified both staff and	

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		individual responses, often with inadequate specification of discrete individual responses (i.e., Individual #172, Individual #68, Individual #167, Individual #42, Individual #312, and Individual #141); ▪ Twelve (100%) appeared to have an adequate description of necessary materials and identified a setting; ▪ Ten (83%) had an adequate description of the schedule of implementation. Those SAPs with insufficient or unclear information about when to implement included those for Individual #172 and Individual #141; ▪ Eight (67%) had sufficient opportunities for learning to occur. Those SAPs with insufficient or unclear information about learning trials included Individual #255 (only once a week), Individual #21 (once a month), and Individual #172 and Individual #141 (undetermined number of learning trials); ▪ Twelve (100%) described relevant discriminative stimuli. Unfortunately, however, nine (75%) appeared to include multiple discriminative stimuli, often in the form of additional, potential unnecessary verbal prompts (i.e., Individual #141, Individual #312, Individual #42, Individual #255, Individual #21, Individual #172, Individual #68, Individual #237, and Individual #167); ▪ Twelve (100%) contained teaching descriptions; ▪ Twelve (100%) conspicuously identified the type of chaining (i.e., forward chaining) utilized in the SAP. However, concerns were noted regarding how the step was identified and how mastery criteria was identified (as discussed below): ▪ Zero (100%) described mastery criteria for moving onto another step within the task analysis; ▪ Twelve (100%) described specific consequences for correct responding. However, all of the SAPs identified multiple prompt levels that would be accepted as a correct response. For example, staff were prescribed to score the trial as a "correct response" if Individual #159 completed the task analysis with either "modeling" or with "partial physical assistance." It was unclear why multiple prompt levels were included, especially given that each SAP indicated "when the person has mastered a skill at a specific prompt level, staff should attempt to remove the prompt assistance, giving the least amount possible to successfully complete the task"; ▪ Twelve (100%) adequately described specific consequence for incorrect responding; ▪ Twelve (100%) identified the use of reinforcers following correct responding. It appeared that the majority included verbal praise as well as other preferred primary and conditioned reinforcers; ▪ Twelve (100%) identified plans for generalization and maintenance; ▪ Twelve (100%) contained documentation instructions; and ▪ Zero (0%) included a criterion for review if limited or no progress was noted,	

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		beyond simply stating "the QDDP will monitor for progression or regression." Overall, the reviewed SAPs appeared to demonstrate slight improvement compared to those SAPs reviewed for the Monitoring Team's previous report. More specifically, the sampled operational definitions appeared somewhat improved and similar improvement was noted with regard to an increasing number of adequate task analyses. In addition, it appeared that more opportunities for learning were provided for individuals and additionally, perhaps more robust reinforcers (i.e., other than verbal praise) were identified. Verbal reports indicated that daily data collection was added to SAPs that targeted skills related to activities of daily living. Indeed, sampled SAPs did evidence daily opportunities for scheduled programming for some of the individuals (i.e., for Individual #147, Individual #237, Individual #167, Individual #42, Individual #312, Individual #159, and Individual #263). However, daily data collection was only still prescribed for two of these individuals (Individual #312 and Individual #159). Although improvement was noted, serious concerns remained regarding other critical and necessary elements of effective skill programming. Overall, concerns remained regarding the structure of the behavioral objective, the multiple discriminative stimuli and/or verbal prompts prescribed, and the lack of adequate task analysis. Indeed, many task analyses did not include specific, discrete individual responses, many included only staff responses or a combination of staff and individual responses, and many appeared seemingly overly complicated or vague. Lastly, some task analyses targeted only verbal responses or appeared to combine multiple complex skills within the same task analysis. These targets of training may not be best targeted by task analyses. The lack of a mastery criterion (i.e., when to change steps or prompt levels), as well as an overall criterion for revision of the entire SAP were also lacking. In addition, although more concrete reinforcers were identified (prescribed for use following correct responding), it was unclear how these would be used effectively (i.e., immediately following a correct response). For example, many SAPs listed reinforcers that appeared difficult to readily access following correct responding, these included tacos and cats (Individual #255), access to a parent (Individual #237 and Individual #21), going to the movies (Individual #141), or getting her hair done (Individual #167). The current findings are consistent with those reported in the Monitoring Team's previous reports and the Facility is encouraged to review previous recommendations regarding critical elements for effective skill acquisition. As reported above, the current examination revealed inadequacies within all of the sampled SAPs and, consequently, they continued to not meet the requirements of the Settlement Agreement. It should be noted that these inadequacies were consistent with those identified in the Monitoring Team's previous reports.	

#	Summary of Provision	Assessment of Status	Compliance
		As previously described with regard to Section C.4 of the Settlement Agreement, based on provided summary documentation, it appeared that approximately 12 medical and 18 dental desensitization plans were developed and implemented within the past six months, between 10/1/12 and 3/31/13. Overall, brief review of provided medical desensitization plans (N=12) revealed a surprising lack of individualization. This finding is similar to reports of limited individualization noted in the Monitoring Team's previous reports. Currently, medical desensitization plans appeared limited to only one or two programs that were utilized for 11 (92%) of the individuals with plans. More specifically, of the 12 medical desensitization plans reviewed, six (50%) utilized the same "waiting in the medical waiting room" plan, and five (42%) utilized the same "blood pressure" plan. Only one of the SAPs reviewed appeared somewhat individualized (i.e., Individual #215). In addition, brief review of provided dental desensitization plans (N=18) revealed somewhat more individualization with eight different programs across the 18 individuals sampled. However, half (50%) of those reviewed either had a tooth brushing or interaction with dental staff SAP. In an effort to determine whether or not progress was made in improving the quality of these plans, compared to those reviewed during the Monitoring Team's previous review, four medical and four dental desensitization plans, completed between 10/1/12 and 3/31/13, were randomly selected from those provided and reviewed. These selected medical and dental desensitization plans reflected a sample of 33 percent and 22 percent, respectively, of those completed over the past six months. These eight plans are identified below: ▪ Medical desensitization plan for Individual #4 targeting blood pressure monitoring (dated 11/15/12); ▪ Medical desensitization plan for Individual #128 targeting waiting in a medical waiting room (dated 11/26/12); ▪ Medical desensitization plan for Individual #215 targeting physical touch by nursing staff (dated 11/15/12); ▪ Medical desensitization plan for Individual #156 targeting waiting in a medical waiting room (dated 11/26/12); ▪ Dental desensitization plan for Individual #65 targeting sitting in the dental chair (dated 10/1/12); ▪ Dental desensitization plan for Individual #87 targeting tooth brushing (dated 11/1/12); ▪ Dental desensitization plan for Individual #215 targeting physical touch (dated 11/15/12); and ▪ Dental desensitization plan for Individual #222 targeting walking to visit the dental office (dated 1/14/13). Of the eight desensitization plans reviewed, the following was noted:	

#	Summary of Provision	Assessment of Status	Compliance
		▪ Zero (0%) had adequate behavioral objectives; ▪ Zero (0%) had an adequate task analysis; ▪ Zero (0%) had an adequate operational definition of the targeted response(s); ▪ Eight (100%) had an adequate description of the schedule of implementation. However, additional specification would be helpful (i.e., identification of specific shift or time of day); ▪ Six (75%) had sufficient opportunities for learning to occur. Those SAPs with insufficient learning trials (i.e., trials only twice a week) included Individual #128 and Individual #156; ▪ Zero (0%) conspicuously identified specific discriminative stimuli; ▪ Three (38%) appeared to have adequate teaching procedures. The exceptions were the plans for Individual #215, Individual #4, Individual #87, and Individual #215 that combined teaching procedures with the task analysis, and the plan for Individual #222 that did not list the current step (objective) in the task analysis; ▪ Zero (0%) described mastery criteria for moving onto another step within the task analysis; ▪ Six (75%) adequately described specific consequences for correct responding. SAPs for Individual #4 and Individual #222 provided inconsistent or vague references to the use of reinforcers following correct responding; ▪ Zero (0%) adequately identified and prescribed the use of a preferred reinforcer other than social praise; ▪ Zero (0%) adequately described differential reinforcement procedures; ▪ Four (50%) adequately described specific consequence for incorrect responding. The exceptions were Individual #128, Individual #156, Individual #65, and Individual #222; ▪ Zero (0%) identified plans for generalization; ▪ Zero (0%) identified plans for maintenance; ▪ Four (50%) adequately described data collection procedures, including how to score correct and incorrect responding; and ▪ Zero (0%) included a criterion for review if limited or no progress was noted, beyond indicating: "revise as necessary." As reported above and with regard to Section C.4 of the Settlement Agreement, the current examination revealed inadequacies within all of the sampled desensitization plans and, consequently, they continued to not meet the requirements of the Settlement Agreement. These inadequacies included, for example, the lack of measurable objectives, inadequate task analyses, omission of prompting hierarchy and related mastery criterion, error correction procedures, emphasis on differential reinforcement, lack of strategies to support maintenance and generalization, and inconsistent documentation instructions.	

#	Summary of Provision	Assessment of Status	Compliance
		Overall, the findings described above in regard to currently reviewed SAPs and desensitization plans are consistent with those identified in the Monitoring Team's previous reports. As found then, given the above findings, it continued to be unlikely that the majority of skill acquisition programs, including desensitization programs, were currently promoting growth, development, and independence across most individuals served at CCSSLC. <u>Engagement Observations</u> Consistent with the Monitoring Team's previous visits, observations during the most recent onsite visit attempted to estimate levels of engagement in recreational, leisure, and/or other activities across residential programs. The Monitoring Team measured engagement across many sites 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. As previously noted, the definition of engagement was very liberal, and included active (e.g., hair care, puzzles, musical instruments, coloring, painting nails, etc.) and passive forms (e.g., listening to the radio or books, watching TV, etc.) of engagement. The table below provides specific information on observed levels of engagement (i.e., individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs.	

Location	***Engaged***	***Staff-to-individual ratio***
522B	1:5	2:5
522A	4:4	2:4
522D	1:2	2:2
522C	1:1	1:1
524C	2:2	1:2
524C	3:3	1:3
524D	6:9	4:9
524B	9:11	2:11
524A	7:10	4:10
514	1:1	1:1
514	1:2	1:2
518	1:1	2:1
524C	3:3	2:3
524D	4:6	2:6
524D	0:2	0:2

Overall engagement was 71%. An engagement level of at least 75% would be a typical target for a facility like CCSSLC. Compared to the estimate of engagement observed during the Monitoring Team's previous visit, the current finding was a substantial

#	Summary of Provision	Assessment of Status	Compliance
		improvement in estimated level of engagement. The Facility continued to actively monitor engagement using 5-Minute Engagement Tools, and, as noted in previous reports, a database had been developed to manage engagement data, and allow examination of current estimates and trends over time, including monthly review by program staff. Previous summary reports indicated that, at times, data might have reflected over-estimation of engagement scores as well as inconsistencies in the number of programs audited per month. However, it was viewed by the Monitoring Team as well as the Facility that this monitoring system continued to appear functional as it provided the opportunity to monitor engagement as well as respond (e.g., action plans) when data reflected less than adequate levels of engagement. Currently, summary data provided continued to reflect the number of engagement tools completed each month (August 2012 to January 2013) across residential and day programs. In addition, estimated engagement based on these completed tools was also similarly graphed. Based on the data provided, it appeared that the number of tools completed each month across residential programs ranged from four to 14 per month. This reflected a completion rate, based on the expectation of two engagement probes completed each week in each residential program, of 92 percent, 75 percent, and 67 percent for programs within the Atlantic, Pacific, and Coral Sea units, respectively. The Facility also reported monthly engagement rates (in bar graphs) across each program as well as average engagement rates across units. The Facility reported consistent engagement rates of above 75% for each program with the exception of below expected performance (less than 70%) for Sand Dollar (in October 2012). This inadequate engagement estimate at Sand Dollar, as reported by the Facility, was similar to previously reported performance within the Monitoring Team's last report, and, according to provided reports, initiated a corrective action plan that was completed 11/30/12. Summary reports also indicated that a recent ICF facility survey found deficiencies in engagement at residential programs in the Pacific and Coral Sea units. Additional, the Facility reported actions were taken in response to these findings, including additional training, more intensive oversight and completion of engagement probes by members of the IDT, including the Residence Coordinator. In addition, action plans targeting zoning and active treatment schedules were implemented. Overall, it appeared that, in some cases, ongoing engagement estimates as determined by the Facility were not consistent with estimates generated by exterior surveyors. This would suggest that, as previously reported, Facility estimates might over-estimate levels of engagement. This was acknowledged by the Facility in recent summary documentation and in reports that indicated an effort to address this tendency through additional training and potential changes to engagement probes that would make the definition of engagement more conservative.	

#	Summary of Provision	Assessment of Status	Compliance
		The Monitoring Team's previous reports evidenced progress over time in developing new vocational, day program, and "retirement" settings on campus in an effort to support individuals in residential programs. In addition, targeted programming for individuals with Autism also had been in development. Current reports indicated that continued efforts at developing individualized programming were ongoing. That is, according to verbal reports, programming related to computer skills, as well as a "fit for life" exercise program, were recently developed. In addition, efforts to provide more flexibility to individuals had been initiated. These included opportunities for individuals to "trial" a program(s) as well as opportunities to access flexible schedules. Previous reports also highlighted evidence that the Facility continued to examine reasons why individuals did not participate in day, vocational, or education programs. Currently, provided documentation evidenced that a corrective action plan targeting the scheduling of respiratory services was successful in facilitating improved participation of five individuals at their day program (Outer Reef). The Monitoring Team's previous reports included recommendations targeting the collection of data on work refusals and/or percentage of time at day or vocational programming to ensure adequate monitoring over time. In response, the Facility had been working to develop and improve this data collection and monitoring system. At the Monitoring Team's previous visit, it appeared that this data system reflected progress and appeared likely to provide important data and effective ongoing monitoring. Currently, provided documentation evidenced continued data collection on classroom and vocational attendance. More specifically, data indicated that percentage classroom attendance (from September 2012 through January 2013) was 69 percent, 84 percent, and 26 percent for Atlantic, Coral Sea, and Pacific, respectively. In addition, data indicated that the percentage of vocational attendance, from September 2012 through January 2013, was 63 percent, 24 percent, and 28 percent for Atlantic, Coral Sea, and Pacific, respectively. It should be noted that some of the variability in attendance rates for Coral Sea and Pacific appeared influenced by the medical isolation experienced in January 2013. At the time of the Monitoring Team's previous visit, the Facility was encouraged to consider monitoring attendance data on an individual basis for select individuals who were the most resistant to attending vocational or day programming. Verbal reports indicated that the data collected using this system was more frequently utilized to increase awareness and improve responsiveness to poor attendance. For example, verbal reports indicated that daily emails were provided to Residence Coordinators and reviewed at morning meetings, data was provided to individuals' IDTs for active problem solving, and monthly/quarterly rewards (e.g., certificates) were awarded for improved or excelled attendance. The Monitoring Team's previous reviews had noted concerns with the limited opportunities for individuals to work off-site in competitive employment positions. Over	

#	Summary of Provision	Assessment of Status	Compliance
		time, the numbers of individuals in supported community-based employment positions had slowly, but gradually grown from approximately seven (at baseline) to 19 (January 2012). The Monitoring Team's last report noted that 20 individuals were working in supported employment positions. Currently, summary data (from the listing on "total number of residents at each site") indicated that approximately 15 individuals were working in community-based sites, including 13 individuals in off-site enclaves and two individuals in off-campus competitive employment positions. In addition, one individual was currently working onsite in a competitive employment position. It should be noted that other summary data (in "Monthly Benchmark Report Section S", dated 2/15/12) indicated that 24 individuals were employed in community settings. Verbal reports indicated that the number of individuals in community-based sites underestimated the Facility's success in placing individuals, due to a number of individuals who had successfully moved into community-based, residential settings. That is, because they moved into new residential programs, their data were no longer included even though they had been successful in remaining in their jobs. The number of individuals supported in employment positions continued to be variable over time as new positions/contracts were added and previous positions/contracts were discontinued. It should be noted that evidence provided suggested that the Facility continued to work with community-based employers to increase the number of off-site positions as well as the contracts available for onsite vocational positions. In this effort, new marketing materials (e.g., pamphlet and DVD) were developed and utilized to promote the skills of the individuals. In addition, the opening of a gift shop (open February 2013) and a coffee shop (opened March 2013) appeared to offer new on-campus opportunities to individuals of the Facility. In addition, the job explorations and vocational tours conducted by educational/classroom staff appeared very active in providing opportunities for individuals to informally experience different types of employment positions and work sites in the community. Efforts at standardizing and responding to interest created by these experiences appeared to be facilitated through the use of a revised "vocational tour" rubric. A database was created to track the progress of these efforts, including data on completed vocational assessments, including situational assessments, as well as vocational tours and job explorations. These efforts reflected improvement by the Facility in monitoring performance over time that was likely to improve vocational/employment outcomes for individuals. Due to the continued inadequacy as noted with the development of SAPs, including in the areas of dental and medical desensitization, and concerns regarding the consistent and adequate engagement across programs, the Facility remained out of compliance with this provision of the Settlement Agreement.	
S2	Within two years of the Effective	Some progress had been noted in the completion of assessments that examined	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
	Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	individuals' preferences, strengths, skills, needs, and barriers to community integration as well as in the areas of living, working, and leisure activities. However, as noted below, concerns regarding the adequacy and/or timeliness of the assessments remained. As described in the Monitoring Team's previous reports, the Personal Focus Assessment (PFA) was used to help teams identify an individual's goals, interests, likes/dislikes, achievements, and lifestyle preferences across a wide range of areas in preparation of the ISP. In the Monitoring Team's last report, it was noted that the Facility was in the process of replacing the PFA with a new Preferences and Strengths Inventory. However, at that time, no PSIs were completed and/or available for review. However, at the time of the Monitoring Team current review, the PSI had been integrated into the ISP process and was, subsequently, included in the present review. In an attempt to estimate the current status of the ISP assessment process, a sample of 12 individuals who had ISPs completed over the past six months (from 10/1/12 to 3/31/13) was selected. This sample reflected approximately 16 percent of those individuals with ISPs held over this time period and was the same sample as previously described in Section S.1. More specifically, a sample of 12 individuals was selected and assessments, including the ISP, ISP Preparation Meeting addendum, PSI, and FSA, as provided, were examined. Currently, of the 12 individuals sampled, 12 (100%) PSIs were dated within the last 12 months. Of these, however, only nine (75%) PSIs were dated on or prior to the ISP Preparation team meeting as prescribed by the current ISP process. More specifically, although PSIs were provided for all of the individuals sampled, the PSIs for Individual #21, Individual #141, and Individual #159 were completed (dated) after the date of the ISP Preparation team meeting (as evidenced by ISP Preparation Meeting addendums dated 4/5/13, 12/5/12, and 8/1/12, respectively). Regardless of the completion date, of the 12 PSIs reviewed, only six (50%) appeared to be adequately completed. That is, one or more sections were not fully completed (Individual #255, Individual #237, and Individual #159) or content within the summary and/or analysis sections appeared cryptic or vague (Individual #147, Individual #21, and Individual #263) for half of those sampled. In addition, it should be noted that only six (50%) listed informants that facilitated their completion, and none of the PSIs were signed. Overall, out of the 12 individuals sampled, it appeared that only five (42%) of their PSIs were current, adequately completed, and available prior to the ISP Preparation Meeting. The Monitoring Team's previous report indicated that 92 percent (i.e., 11 of 12 individuals sampled) had completed FSAs. However, at that time, closer review of sampled FSAs evidenced recommendations that appeared quite brief and non-specific. That is, most of the FSAs reviewed contained three to five recommendations that each included only one word (or just a few words) describing a common label or category of skills/activities of daily living (e.g., "Community," "Leisure," or "Money Management"). It	

#	Summary of Provision	Assessment of Status	Compliance
		was unclear to the Monitoring Team why such a comprehensive assessment (47 or more pages), that required significant resources to be completed, would produce such brief and often cryptic recommendations. Unfortunately, similar findings were observed in the current review. Provided documentation evidenced revisions to the format and content of the FSA since the Monitoring Team's last visit. That is, additional content areas were added to the summary and recommendation section of the FSA. These included sections on identified preferences, strengths, needs, goals, barriers to community integration, supports needed to overcome barriers, and skill training recommendations. According to provided documentation, on October 23, 2012, staff members were trained on the revised FSA. Currently, of the 12 individuals sampled, 12 (100%) had FSAs completed within the last 12 months and dated prior to the ISP. Of these, five (42%) were completed using the new FSA format (these included the FSAs for Individual #172, Individual #68, Individual #21, Individual #167, and Individual #312). This new standardized format allowed the IDT to more comprehensively discuss and summarize the results in regard to an individual's preferences, strengths, needs, goals, barriers to community integration, skill training recommendations, and ideas for the future. Of the five FSAs completed using the new format, only three (60%) appeared adequate. That is, the FSAs for Individual #68 and Individual #167 contained vague recommendations and provided insufficient summary of identified needs, respectively. Of the 12 FSAs reviewed, four (33%) contained vague recommendations. This finding, of non-specific recommendations, was similar to the finding reported in the Monitoring Team's previous report. Overall, out of the 12 individuals sampled, it appeared that only three (25%) of their FSAs were adequately completed using the new format. According to provided summary data (Vocational Assessments Completed 5/1/12 to 2/1/13), it appeared that approximately 158 vocational assessments were either completed or updated between 10/1/12 and 2/1/13. Of these, it appeared that approximately 38 (24%) were "updated" (i.e., "updated" was typed above or near the completion date on the vocational assessment). In an effort to review the adequacy of current vocational assessments, ten individuals with recently completed vocational assessments were reviewed. The Facility selected this sample of vocational assessments, and it appeared to reflect approximately six percent of those completed between 10/1/12 and 2/1/13. Of the ten vocational assessments provided for review: ▪ Ten (100%) were either completed or updated within the past 12 months. However, of these, eight (80%) vocational assessments appeared completed prior to the ISP meeting (exceptions included Individual #4 and Individual #31); ▪ Four (40%) appeared to be "updated," but it was unclear what information in the report was new or revised. More specifically, it was not conspicuous what	

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		content within the assessment was new or updated for Individual #297, Individual #62, Individual #237, and Individual #255; ▪ Seven (70%) identified vocational/employment visions that included specific language related to current or future employment aspirations. Exceptions included Individual #158, Individual #4, and Individual #31. In these exceptions, the content within the assessment simply indicated that the individual did not express any interest in working; ▪ Four (40%) indicated specific ideas related to future employment (i.e., Individual #62, Individual #237, Individual #55, and Individual #255). However, of these four, two (50%) provided somewhat vague descriptions that did not appear to be helpful (i.e., Individual #62 and Individual #237); ▪ Seven (70%) had specific recommendations related to employment-related activities or prerequisite skills. Exceptions included Individual #158, Individual #4, and Individual #31; ▪ Five (50%) appeared to have situational/vocational explorations completed within the last 12 months. These included off-site (Individual #62, Individual #237, and Individual #157) and on-site situational assessments (Individual #55 and Individual #255). It should be noted that several vocational assessments did not specify dates of some situational assessments identified (i.e., Individual #69 and Individual #157). Consequently, it was unclear when these were completed; and ▪ Four (40%) contained graphic displays of related SAPs (i.e., Individual #158, Individual #297, Individual #62, and Individual #255). When graphic displays were provided, none (0%) were interpretable. Overall, review of sampled vocational assessments reflected some improvement in the number of situational assessments completed, including those completed in off-site vocational settings. Provided summary documentation indicated that approximately 58 situational assessments had been completed (October 1, 2012 through February 1, 2103) with approximately 23 (40%) leading to "successful placement" for individuals assessed. Provided summary data indicated that, of the assessments completed or updated between 10/1/12 and 2/1/13, vocational or employment visions were only identified for 37 (23%) individuals. That is, summary documentation indicated that over 75 percent of the vocational assessments completed during this time period did not identify a vocational vision. More specifically, for these individuals, summary documentation either indicated "No Vision identified" or "No Vision Identified – update." The new Section S Policy - Education and Training Assessment (dated 1/17/13) indicated that Vocational Updates only provided information on changes in individual preferences or skills related to work and, perhaps, this was the reason no specific visions were identified. In addition, it was difficult for the Monitoring Team to discern any new or	

#	Summary of Provision	Assessment of Status	Compliance
		revised information within assessments that were "updated." That is, new or revised information within the assessment (including related implications) was not conspicuous. Consequently, the Monitoring Team questioned the ultimate usefulness of this assessment. Indeed, the Facility reported that employment visions were not identified for the majority of individuals assessed. In addition, the majority of identified visions continued to appear limited to what was available on campus. Continued emphasis should be placed on the completion of community-based situational assessments or perhaps more novel onsite situational assessments. As noted in many of the Monitoring Team's previous reports, the utility of the vocational assessment will continue to improve as its findings are based on meaningful situational assessments, including a greater diversity of experiences potentially available in community-based, off-site settings. Their value also will improve as the results are linked directly to functional skill acquisition programs related to achieving individualized employment visions. It should be noted that vocational staff were trained in a revised Vocational Assessment on October 25, 2012. Revisions appeared to target the integration of services with regard to the individual's preferences, strengths, and goals. In addition, according to verbal report, since January 2013, information related to the vocational tours and job explorations had been integrated into vocational assessments. In the Monitoring Team's previous report, the Monitoring Team recognized the efforts at utilizing (or at preparing to utilize) other standardized and structured assessments (e.g., the ABLLS-R, etc.) in an attempt to better support individuals in educational settings. At that time, initial efforts to more broadly utilize evidence-based assessments and skills training curricula appeared promising. Verbal reports from educational staff at the time of the current monitoring review indicated continued efforts at utilizing these types of assessments and curricula. Indeed, verbal reports indicated the continued use of standardized assessments of individuals supported within the Comfort Zone. Based on verbal reports and provided documentation, one structured assessment that appeared to be utilized with individuals within the Comfort Zone was the Picture Exchange Communication System (PECS): Implementation Checklist. In an attempt to review how these were completed, documentation was requested for a small sample (n=5) of individuals at the Comfort Zone. The Facility provided documentation completed for five individuals, including Individual #155, Individual #6, Individual #198, Individual #371, and Individual #147. Upon review, PECS implementation checklists were available for four (80%) of the individuals. The exception was Individual #60. Of these, zero (0%) appeared to be completed based on observations completed within the last 12 months. Although one of the assessments had a completed summary section (dated 6/4/12), it was unclear what observations this summary was based on as previously noted observations only occurred in December 2011 and January 2012. Although seemingly	

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		outdated, the assessments and related summary appeared to be based on multiple observation sessions (i.e., eight sessions over a four or five-week period). Based on provided documentation, it was unclear to the Monitoring Team how this information was utilized to monitor progress or inform treatment over time. SAPs for one of the individuals (Individual #147) were examined and a connection to this assessment could not be determined. An additional assessment, the Implementation Checklist for Structured Work Systems, also was provided for three individuals, including Individual #147, Individual #371, and Individual #60. It was not clear why this assessment was not completed and/or available for Individual #155 or Individual #198. Of these three individuals, three (100%) appeared to be completed within the last 12 months. Indeed, for two of these individuals (i.e., Individual #147 and Individual #60), the assessment appeared to be completed on two different occasions, suggesting progress monitoring over time. However, the assessment for Individual #147 was completed only once. In addition, the same recommendations made over time (e.g., "… next step is to provide [Individual #60] a picture schedule…" on 4/27/12 and "a picture schedule will be developed …" on 6/18/12) raised concerns about the timeliness and ultimate utility of their completion. Overall, based on provided documentation as related to both assessments, it was unclear to the Monitoring Team that these assessments were effectively utilized in monitoring and informing progress and treatment over time. Provided documentation evidenced revisions to the format and content of the Education and Training Assessment since the Monitoring Team's last visit. That is, additional content areas were added to assessment based on information obtained from the ISP Preparation meeting, PSI, and personal preferences. These content areas included sections on identified preferences, strengths, needs, goals, barriers to community integration, supports needed to overcome barriers, and skill training recommendations. According to provided documentation, on October 24, 2012, staff members were trained on the revised Education and Training Assessment. Due to the continued concerns with regard to the adequacy and timeliness of completed assessments as noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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		

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	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	Efforts were noted with regard to the development and training of SAPs, - however, concerns remained regarding their quality, including the rationale cited for their development as related to completed assessments. The Monitoring Team's previous reports noted that a weekly peer review process, entitled the "Skill Acquisition Review Committee," was in place to examine developed skill plans and to provide feedback and ongoing coaching, and refinement. According to verbal reports and onsite observation, this committee continued to meet weekly to review developed plans. This included the use of a SAP rubric to assist in the development and critical review of SAPs. The committee had received technical support from one of the contracted BCBAs, the Clinical Psychologist, and Chief Psychologist. Based on findings from the current review (as discussed with regard to Section S.1), robust clinical and technical support continued to be necessary. This might include, for example, further examination and revision of the current SAP rubric, consistent with current findings, which would likely improve the development and critical review of SAPs. For example, the current rubric might be revised to ensure that behavioral objectives and operational definitions include only objective and measureable responses. In its current form, the rubric indicated that the operational definition "clearly and specifically explain how the skill is taught." However, an operational definition should only clearly describe the response being targeted using behavioral and measureable terms. The current rubric did not describe all necessary teaching methods, including type of chaining as well as mastery criteria for the identified step. In addition, the rubric could be revised to ensure that task analysis includes only discrete, individual responses (and not staff behavior). In an effort to examine whether or not SAPs effectively addressed the individuals' needs for services and supports, randomly selected SAPs were examined in a sample of individuals who had ISP meetings held since the Monitoring Team's last visit. The sample reviewed here was the same sample as previously described with regard to Sections S.1 and S.2. More specifically, available documentation was reviewed to determine if sampled SAPs were based on specific needs identified by currently completed assessments. As previously reported with regard to Section S.1, although rationales were found for all 12 (100%) of the individuals, concerns were noted with regard to the assessments cited within these rationales. Overall, each of the SAPs included rationales that listed multiple sources, including specific assessments (e.g., PSI, FSA, Nursing Assessments, Integrated Risk Form, etc.), discussion at the ISP, and the task analysis included in the current SAP. It should be noted that several of the identified assessments were not available to the Monitoring Team at the time of the offsite	Noncompliance

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		document review. This included the Stop Assessment for Individual #255, the Nursing Assessments for Individual #172 and Individual #42, and the Integrated Risk Rating Forms for Individual #237 and Individual #312. Of the 12 individuals reviewed: ▪ Eleven (92%) of the SAPs indicated that they were based on preferences identified within the PSI. However, preferences related to the SAP (or integrated within specific SAP methodology) were only conspicuous in four (36%) of the PSIs reviewed. More specifically, it was unclear to the Monitoring Team how preferences identified within the sampled PSIs were related to the identified SAPs for the remaining seven individuals sampled (i.e., Individual #255, Individual #172, Individual #147, Individual #237, Individual #167, Individual #312, and Individual #159). ▪ Six (50%) of the SAPs indicated that they were based on preferences identified within the FSA. This included identified SAPs for Individual #147, Individual #68, Individual #21, Individual #141, Individual #159, and Individual #263. More specifically, half of the SAPs sampled appeared to target skill deficits as identified by the FSA. However, the Monitoring Team could only establish a link between the FSA and the selected SAP for four (67%) of the individuals sampled. It should be noted that, at times, this link appeared tentative at best. More specifically, a conspicuous link between the FSA and the identified SAP was not obvious for Individual #147 and Individual #263. Scored items on the FSA for Individual #147 appeared to demonstrate primarily independent responding (in the area of dressing) for Individual #147 that, if accurate, negated the need to target these same skills through a SAP. In addition, the SAP for Individual #263 identified "… vocational deficits identified in the functional skills assessment …" as part of the rationale for the selected vocational skill program. However, the FSA did not include items targeting vocational skills. Consequently, it was unclear to the Monitoring Team which specific items were the basis for the SAP. Lastly, although the FSAs included scored items that appeared related to the needs addressed in the SAPs for Individual #21, Individual #141, and Individual #159, specific recommendations targeting these skills were either not identified or were somewhat inconsistent on the FSA. ▪ Twelve (100%) of the SAPs identified "… discussion of training at ISP …" within the rationale for each sampled plan. It should be noted that IDT discussion at the ISP was not viewed as an acceptable replacement for the completion of assessments. Overall, the utility of the PSI and FSA in identifying areas for skill acquisition was not conspicuously demonstrated for the majority of individuals in the current sample. Based on the current review, if the PSI was instrumental in the development of SAPs as suggested by its reference in most rationales, it was not easily observed in the current sample. In addition, it was surprising that only half of those SAPs sampled identified the	

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		FSA as a basis for skill planning and, as noted above, in many of those cases, it appeared that the assessment was not utilized correctly or identified needs were not readily highlighted through descriptive recommendations. Indeed, when referenced, the recommendations following the completion of the FSA did not typically appear directly linked to skills targeted within the sampled SAPs. As noted with regard to Section S.2, the Monitoring Team's previous reports found recommendations in FSAs quite brief and non-specific. It continued to be unclear to the Monitoring Team why such a comprehensive and resource-dependent assessment would produce such brief and often cryptic recommendations. The Monitoring Team questioned, again, the ongoing utility of this assessment if more comprehensive and detailed recommendations for skill programming were not provided. In an effort to examine whether or not SAPs were practical and functional in the most integrated setting, the prescribed settings of current SAPs were examined. As described with regard to Section S.3.b of the Settlement Agreement, all 12 (100%) of the individuals currently sampled had at least one SAP targeting completion in a community setting. However, as discussed below, concerns were noted regarding regular access to opportunities for community integration. Twelve (100%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings, and 12 (100%) had at least one SAP targeting completion in the residence. Of the individuals sampled, 11 (92%) appeared to have SAPs that were functional. More specifically, the SAPs appeared to target skills that were meaningful and potentially productive. The exception was the SAP for Individual #21 that targeted increasing community awareness (i.e., turning his head and looking around). It was unclear to the Monitoring Team how the IDT for Individual #21 would ever know if community awareness had been achieved. Indeed, the majority of SAPs were prescribed for completion in the residential settings. Although significant concerns about the adequacy of sampled SAPs were noted above (with regarding to Section S.1 of the Settlement Agreement), based on the targeted behavioral objective and the identified setting for training, it appeared that all 12 (100%) individuals had opportunities for skill acquisition in the most integrated setting. As reported in the Monitoring Team's previous report, skill acquisition training curriculum had been integrated into the New Employee Orientation (NEO). Verbal reports and provided documentation indicated that training on SAPs continued to be covered in NEO and that competency-based testing, using the integrity rubric, had been integrated into this training as well. This training was described as very comprehensive. In addition, a new Certified Trainer program was implemented to train staff to competency as trainers of SAP programs. These trainings started in January 2013 and approximately 40 or more staff had been trained and passed the Certified Trainer Exam.	

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		In addition, SAP refresher training classes were also offered to staff members. Verbal reports indicated that these exams and refresher trainings would continue in the future. As reported in the Monitoring Team's previous reports, the Facility continued to utilize integrity checks to assess staff competency in implementing SAPs. That is, integrity check audits continued to be completed in residential programs and monitored using a database that tracked the number of audits for each program as well as information on individual, auditors, audit date, and integrity score per month. Examples of this database (November and December 2012) were provided for review and appeared to facilitate effective review and retraining when necessary. Provided summary data indicated that 86 integrity checks were completed across residential programs between September 2012 and January 2013 and resulted in an overall competency score of 86 percent. However, the Facility reported competency appeared poorest with regard to how staff responded to incorrect responses and how to collect data. The current rubric, "Integrity Check for Skill Acquisition Plan," was revised to include more items scored through demonstration as well as items related to prompt sequence, generalization and maintenance. Provided training documentation indicated that staff members were trained on this new rubric on October 23, 2012. Consistent with the Monitoring Team's previous reviews, concerns regarding the adequacy of integrity checks were noted during current, direct observation of integrity checks. Consistent with previous observations, currently reviewed integrity check sessions reflected the need for ongoing support and training for active treatment staff who conduct these sessions. That is, continued difficulty in understanding the necessary elements of the SAPs, how they are implemented, and how the integrity check is scored was obvious during the integrity checks observed. Consequently, the brief and limited direct observations the Monitoring Team made did not reflect the high degree of integrity estimated by the Facility as reported above. The Monitoring Team recognizes that completing integrity checks with a high degree of fidelity and reliability is challenging and, like other challenging skills, requires sufficient competency and experience to master. Consequently, ongoing training should continue to be provided to ensure these are completed accurately. It appears promising that more rigorous training has been initiated and that increasing numbers of "certified trainers" are available to train, monitor, and provide coaching as necessary. During previous Monitoring Team's reviews, it was reported that the Facility had implemented weekly checks examining the quality of data collection for SAPs. That is, active treatment staff members assessed the adequacy of data collection for each skill plan across all individuals in a residence each week. This ongoing evaluation of data collection appeared to offer an effective way to regularly and systematically monitor the adequacy of data collection, as well as to prompt feedback or initiate further examination	

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		when inadequate data collection was observed. This feedback had included notifying the Home Team Leader or supervisor. At the end of the month, this data was reviewed and summarized by the program coordinator. Currently, summary data of completion rates (i.e., total percentage of data collection) per home was graphed across units from July 2012 through January 2013. Overall data reflected scores for total completion at or greater than 81 percent for all residences across the seven-month period. Brief onsite reviews during the Monitoring Team's current visit also evidenced improved findings with regard to the completion of data collection. That is, brief record reviews examining the collection of behavioral data indicated that 100 percent, 83 percent, 100 percent, 85 percent, 89 percent, 100 percent, and 78 percent appeared collected as prescribed for Individual #211, Individual #165, Individual #237, Individual #174, Individual #58, Individual #9, and Individual #273, respectively. Brief reviews of skill acquisition plan data indicated that 83 percent, 100 percent, 100 percent, and 100 percent of the data appeared collected as prescribed for Individual #211, Individual #165, Individual #224, and individual #174, respectively. It appeared that increased vigilance of data collection by behavioral services and active treatment staff had improved the completion of behavioral and skill acquisition data. At the time of the Monitoring Team's previous visit, evaluation of ISP monthly reviews evidenced significant concerns regarding the adequacy of monitoring progress of skill acquisition programs. More specifically, at that time, the review found none (0%) of the ISP monthly reviews for selected SAPs adequate. The Monitoring Team's current review found similar findings following the most recent review. More specifically, a section of selected SAPs, sampled monthly data sheets (last two months), and ISP monthly reviews (last two months) were reviewed. This sample was the same sample as previously described (with regard to Section S.1 and S.2). The following quantifies the results of the Monitoring Team's most recent review, that is, of the 12 individuals sampled: ▪ Ten (83%) evidenced data collection during both February and March 2013. Exceptions included Individual #255 and Individual #68; ▪ Six (50%) evidenced the collection of data as prescribed (examples of concerns are noted below). Exceptions included Individual #255, Individual #21, Individual #167, Individual #42, Individual #141, and Individual #159; ▪ One (8%) appeared to have both February and March ISP Monthly Reviews completed and available for review as requested (i.e., Individual #255). It should be noted that additional months (e.g., December 2012 and/or January 2013), although not requested, were provided for almost all individuals reviewed as well; ▪ Eight (67%) had graphic display of data in one or more of the ISP monthly reviews. Exceptions included Individual #172, Individual #237, Individual #68, and, Individual #21;	

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		▪ Of those with graphic displays, in one or more of the ISP monthly reviews, two (25%) appeared to have the appropriate data displayed. That is, extra data points/paths appeared to be inaccurately displayed in six (75%) of those sampled (i.e., Individual #147, Individual #167, Individual #42, Individual #141, Individual #159, and Individual #263); ▪ Eleven (92%) had ISP monthly reviews that contained a signature and date; and ▪ Six (50%) appeared to be completed within an appropriate period of time. More specifically, half of those sampled had ISP monthly reviews completed two or more months following the month in which the data was collected (i.e., Individual #68, Individual #167, Individual #42, Individual #141, Individual #159, and Individual #263). Specific descriptive examples of continued inadequacies found during the current review included: ▪ It was unclear why full physical prompting, which was documented on two separate trials (i.e., 2/21/13 and 2/26/13), was necessary for Individual #255 to demonstrate a correct verbal response (i.e., February 2013 SAP data sheet); ▪ The goal identified on the ISP Monthly review (i.e., identifying triggers) for Individual #255 did not match the current step (i.e., how he interacts with others); ▪ Graphic displays continued to be found on monthly raw data sheets. The value of the continued inclusion of these graphs was unclear especially when they were incomplete or inadequate in five (42%) of those sampled. These included Individual #68, Individual #21, Individual #167, Individual #312, and Individual #159; ▪ It appeared that staff did not either understand how to run and/or score a trial (including the prompt level) or understand the criteria for a successful trial for Individual #167 (SAP data sheets for February and March 2013), Individual #141 (SAP data sheet for March 2013), and Individual #42 (SAP data sheet for March 2013). That is, in all of these examples, staff erroneously recorded multiple prompt levels on a single trial on provided monthly raw data sheets; ▪ Correspondence between scored items on the raw data sheets did not appear consistent with data presented on graphs in ISP monthly reports for Individual #312. More specifically, although 23 trials (out of 31) were successfully completed (according to included instructions), the ISP monthly review indicated that "1" trial was successful (i.e., February 2013); ▪ Performance was graphically displayed as "0" successful trials even though no data was collected in February 2013 (due to absences) of Individual #141; ▪ No summary or recommendation was found on the January 2013 ISP monthly review for Individual #263; ▪ Data appeared to be inaccurately reported in the February 2013 ISP monthly	

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		review for Individual #237 based on data presented in January 2013; and ▪ The selected SAP was not reviewed in any of the ISP monthly reviews provided for Individual #68. Overall, the Monitoring Team continued to find the majority of graphic displays inadequate. Many of the monthly reviews did not include graphic displays of performance on SAPs and, when they were available, they were difficult to interpret. It also continued to remain unclear why graphic displays were found in both the SAP and ISP monthly reviews. This was especially true when many of the graphic displays in monthly data sheets appeared incomplete. As reported in the Monitoring Team's previous reports, the utility of SAP data as presented in ISP monthly reviews was limited. That is, prompting levels were not always consistently recorded in ISP monthly reviews. Related to this, the nature of prompting (i.e., what level of prompting was required or when to change prompt level) could not be determined within current documentation. Indeed, raw data sheets provided multiple examples of where the prompt levels were recorded inaccurately. Graphic displays continued to present data across months (on the X axis). As previously reported, this data point was likely the average of four or less trials. In addition, the frequency of successful trials (displayed on the Y axis) was utilized in all graphic displays across all sampled SAPs. This might be restrictive as some SAP data may be better displayed as percentage of trials. Lastly, there were multiple data codes, in addition to "+" correct and "-" incorrect, that were used to describe performance. These codes included "A" (absent) and "R" (refusal), in addition to prompt level, and were often not adequately reflected within graphic displays. Consequently, graphic displays did not adequately reflect true performance and might lead to misinterpretation. As consistent with previously reported findings, the Facility continued to need an ongoing data collection and monitoring system that addressed the above concerns. Indeed, the Facility had recognized the poor quality of the Monthly Reviews as evidenced by the corrective action plan recently implemented. In addition, trainings on revised SAPs, including graphic displays, had been completed (dated 10/23/12). However, based on the current review, the Facility should review the Monitoring Team's previous findings and recommendations related to data collection, data display (i.e., including standards of graphic display), and ongoing performance monitoring, and integrate these into current corrective efforts. It was noted that a second trial opportunity was added to many SAPs following incorrect responding on the initial trial. Consideration should be given to collecting data on every teaching trial conducted and, when appropriate, designing skill programs that can accommodate many trials (e.g., 10 or more) in a single session, when appropriate. In general, the Facility's attention to supporting better data collection of skill	

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		programming was noted. However, these improvements did not appear to translate to improved monthly progress monitoring. Given the above concerns regarding the development, training, and monitoring of SAPs, the Facility remained in noncompliance with this provision of the Settlement Agreement.	
	(b) Include to the degree practicable training opportunities in community settings.	Continued progress was noted in developing skill acquisition programming opportunities within the community. However concerns were noted with regular access to community integration. The Monitoring Team's previous reports noted consistent progress over time in the number of individuals with formal opportunities to engage in skill acquisition programs within the community. Currently, as described previously with regard to Section S.1, the SAPs of a sample of 12 individuals with ISPs held within the last six months (10/1/12 through 3/31/13) was selected and reviewed. This review included an attempt to identify the prescribed settings of sampled SAPs, including the degree to which training opportunities were prescribed in community settings. Overall, 12 (100%) had at least one SAP targeting completion in a community setting. The current findings reflected continued improvement in ensuring individuals had opportunities to work on the acquisition of skills in community settings. However, as specifically discussed below, it appeared that opportunities to participate in skill programming as prescribed by SAPs was limited in a number of residential programs by restricted community outings. In addition, concerns with regard to the quality of these SAPs, as discussed in further detail with regard to Section S.1, limited actual potential of these experiences as authentic learning opportunities. Community integration summary data, from September 2012 through January 2013, was provided for review. Although community trips appeared to remain consistently high for the Atlantic residential programs across this time period, lower total trips per month, as well as a decreasing trend across months, were reported for the Pacific and Coral Sea residential programs. This data reflected inadequate opportunities for community integration for Atlantic and Pacific units. One variable that was offered as part of the explanation for inadequate outings included that both of these units were on isolation in the month of January 2013. In addition, data on the number of individuals who participated in community outings for January 2013 appeared adequate for Atlantic units, but not for Pacific or Coral Sea. Documentation indicated that corrective action plans were developed for Coral Sea and Pacific residences and recent improvement in community integration was reported. The Facility should continue monitoring community outings data, and consider examining and reporting percentage of individuals participating in outings per month across each residence as well.	Noncompliance

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		One of the consistently reported challenges to community integration identified during previous visits was the limited availability of adequate transportation. As previously noted, three vans were purchased (in November 2010) to support community integration and supported employment. According to current verbal reports, two paratransit buses were purchased (in October 2012), and had been very helpful in supporting the community integration of greater number of individuals, including individuals in wheelchairs. Due to the continued inadequacy and concerns related to the quality of the plans developed to support community training opportunities as well as adequate opportunities for community integration, the Facility remained out of compliance with this provision of the Settlement Agreement.	

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

1. The State Office should assist the Facility in identifying or providing staff with expertise in skill acquisition as well as writing and monitoring skill acquisition programming. This likely will require the involvement of Behavioral Services and/or Special Education staff that have competency in these areas. Using such resources, robust competency-based training and retraining should be provided to the staff currently developing, monitoring, and training the implementation of SAPs. This should include developing multiple exemplars (e.g., SAPs, data collection methods, monthly monitoring/review notes) that could be used by staff to address needs typical to individuals in residential settings. Staff should then use these exemplars as a foundation to individualize subsequent SAPs. Ongoing on-site critical review, training, and support by expert staff should occur on a weekly or monthly basis. (Section S.1 and S.2)
2. The Facility should ensure that assessments listed as part of the rationale provide clear evidence of the link between the identified need and the skill targeted within the skill plan. Ensuring specific citation of items and/or sections of assessments within rationales might improve the accuracy with which these rationales are identified. (Section S.1)
3. The Facility should ensure that SAPs are based on identified needs as found in assessments. That is, needs should not be identified through task analyses. (Section S.1)
4. If not already in place, a process should be developed and implemented to describe how preferences identified within the PSI or FSA are incorporated into skill programs. (Section S.1)
5. The Facility should expand its use of the "test trial" for 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. The planning and validating of each task analysis should occur prior to training and staff should expect that adjustments would likely be necessary. (Section S.1)
6. As previously recommended, the identification of specific prompt levels should be eliminated within behavioral objectives, because this appears to necessitate more frequent revisions of the program or, if including reference to a prompt level is desired, an "independent level" of responding could be stated (following the initial instruction) when writing most behavioral objectives. In addition, criteria for mastery (moving up a step in the task analysis) should not be included in the behavioral objective, but rather in the instructions section. Consideration should be given to standardizing the mastery criteria, when appropriate. (Section S.1)
7. Skill Plans should utilize a more generalized discriminative stimulus that does not include specific steps of the task analysis. This instruction should cue completion of the entire task analysis and should reduce the amount of necessary revision as the individual makes progress. (Section

S.1)

8. Redundancy of information across sections in the skill acquisition plans should be avoided. Instructions, discriminative stimuli, error correction, reinforcement procedures, and data collection procedures, for example, are not necessary under the methodology section, if they are sufficiently described in other sections. (Section S.1)
9. Efforts should be made to ensure that each task analysis is adequate, that is, not subjective or overly comprehensive or complex (i.e., not trying to do too much or includes staff responses), or does not have sufficient detail to ensure identification of a correct response(s). They should be complete, detailed, and accurate. (Section S.1)
10. More training should be provided on behavior chains, including task analysis, discriminative stimuli, differential reinforcement, and the collection of data appropriate to the type of chaining procedure prescribed. That is, total (whole) task presentation provides training to the individual on each step of the task analysis during every session. (Section S.1)
11. Plan authors should ensure the prompt sequences in skill plans are appropriate, especially when primarily targeting verbal responses. In addition, multiple prompt levels should not be included in the criterion for a successful trial. (Section S.1)
12. When appropriate, more frequent teaching opportunities should be prescribed for skill acquisition programs. 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. (Section S.1)
13. The error correction procedures should be standardized across all skill acquisition plans, when appropriate. This should not include data collection procedures, but rather descriptions of how staff respond to errors (i.e., avoid provision of reinforcers). Additional staff instructions (e.g., explanations, second chances, specific prompting sequences) should be avoided and not included in this section. (Section S.1)
14. Consideration should be given to standardizing when staff members evaluate performance on a SAP. That is, the authors of SAPs should consider determining performance (correct or incorrect responding) on the first trial. (Section S.1)
15. 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. Staff instructions should avoid the use of supplemental verbal responses from staff, because this is likely counterproductive and inconsistent with the prompting hierarchy. (Section S.1)
16. Differential reinforcement should be used 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 obvious and easy for staff to implement. (Section S.1)
17. Reinforcement procedures should be part of every skill acquisition plan and reinforcers should be individualized, when appropriate. (Section S.1)
18. Preference assessments should be regularly completed with all individuals, and the results should be conspicuously noted in skill acquisition plans, PBSPs, etc. (Section S.1)
19. The Facility should examine the usefulness of the current data sheet used for SAPs and consider adopting a data form that allows the collection of data during each learning trial. This could include the identified step of the task analysis and prompt level. This type of system would be responsive to individuals who proceed quickly through a task analysis. (Section S.1)
20. The IDTs of individuals currently not attending a day or vocational program away from their residential unit should continue to meet to identify the barriers to participation and problem-solve to assist, as appropriate, individuals in overcoming such obstacles. IDTs should review such reasons and justifications regularly and document these in the ISP, as well as progress made in assisting individuals to overcome such obstacles. (Section S.1)
21. As appropriate, behavioral supports should be developed for individuals to support their participation in meaningful day and vocational programs. (Section S.1)
22. The Facility should continue to track program attendance (e.g., vocational, work, class, etc.) and monitor ongoing performance of individuals or

programs over time. This would facilitate the identification of individual improvement or decline, and allow closer examination of the effectiveness of current supports. (Section S.1)

23. Generally accepted graphing conventions still should be used when displaying data across all assessments and monthly reviews (specific recommendations regarding graphing are offered with regard to Section K). (Section S.1)
24. 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 psychology and active treatment as teams work to develop skill acquisition programs, including effective monthly monitoring. (Section S.1)
25. The Facility should ensure that all assessments are adequately completed, including summary and recommendation sections of the PSI and FSA, prior to the ISP meeting. (Section S.2)
26. When monitoring vocational data, the Facility should clearly indicate whether or not situational assessments were completed in on- or off-site settings for each individual listed. (Section S.2)
27. Situational assessments on-site should continue, but with the understanding that these still potentially limit the vocational visions of some individuals. Community-based vocational assessments should be pursued as well, because these might offer more diverse vocational opportunities. (Section S.2)
28. The Skill Acquisition Review Committee should pursue consistent and ongoing collaboration with the State Level Consultants and the Psychology Department for technical support when developing, implementing, and monitoring skill acquisition programs. (Section S.3.a).
29. Further training of active treatment staff on completing skill plan integrity checks should be completed. This includes training on completing IOA probes. (Section S.3.a)
30. Data should continue to be collected and summarized to allow monthly examination of integrity checks of skill plans across programs. (Section S.3.a)
31. The Facility should continue to examine, summarize, and monitor systems necessary to provide effective competency-based training for direct support professionals on the implementation of skill acquisition plans. (Section S.3.a)
32. The Facility should continue to collect, summarize and monitor community outing data, including data on SAPs completed within community settings. The quality of the community outing also should be rated in terms of meeting individuals' preferences and offering opportunities for community integration. (Section S.3.b)

The following is offered as an additional suggestion to the State and Facility:

1. If not already in place, a spreadsheet should be created that tracks community-based supported employment and that would allow ongoing assessment of trends over time. This should identify each individual, the setting(s) in which they work, the number of hours worked per week (average and range) per site, and the dates of employment per site. New positions each month (or quarter) should be highlighted. (Section S.1)

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 In response to request for State and Facility policies and procedures related to assessment of individuals for community placement, the development of individual plans, and individual transition and discharge, the response: "No changes have occurred since the last on-site review;" o Community Placement Report for period between 6/1/12 and 1/31/13, dated 3/11/13; o List of individuals currently referred for community placement, dated 3/11/13; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated; o List of individuals who have requested community placement, but have not been referred, dated 2/13/13; o List of those individuals who have not been referred solely due to LAR preference, whether or not the individual himself or herself has expressed a preference for referral, dated 2/13/13; o Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2012, data as of 8/31/12; o Annual Report: Obstacles to Transition Corpus Christi State Supported Living Center, Fiscal Year 2012, prepared November 2012; o List of individuals transitioned to community settings, from 8/1/12 through 1/31/13; o List of training/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices related to community transition for past 12 months, including to sign-in sheets; o List of all training and educational opportunities that address community living, including but not limited to provider fairs, community living option in-services, and/or onsite visits to community homes and resources provided to Facility staff; o Facility and Local Authority staff training curricula related to community living, transition and discharge, including training materials; o Community Living Discharge Plans (CLDPs), including individuals' most recent ISP and related assessments for Individual #140, Individual #231, Individual #63, Individual #213, and Individual #341; o CLDPs for: Individual #71, Individual #62, and Individual #208; o List of alternate discharges, dated 11/18/12; o List of individuals transferred to other SSLCs, dated 2/20/13; o List of alleged offenders, dated 11/18/12; o Summary of the obstacles identified for individuals' movement to the most integrated setting, dated 2/18/13; o For the last one-year period, a list of individuals who have transitioned to the community

	indicating whether or not since their transition, 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; and/or 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason, undated; o In response to the request for any facility-wide needs assessments related to the provision of community services to people with developmental disabilities and obstacles to such placement, the response: "A Living Options discussion is now included in the Annual ISP shell so each resident will have a Living Options Discussion annually. A Living Options Addendum is completed for the individual when an individual is referred for community placement;" o Individual Support Plans, Sign-in Sheets, and Assessments for the following: Individual #58, Individual #311, Individual #279, Individual #301, Individual #59, Individual #298, Individual #111; o List of Post Placement Monitoring, dated 2/20/13; o Pre-Move and Post-Move Monitoring documentation for the following: Individual #231, Individual #69, Individual #208, Individual #62, Individual #71, Individual #341, Individual #63, Individual #213, and Individual #140; o Last 10 monitoring tools completed by: a) Admissions Placement Coordinator; and b) Quality Assurance Department staff, various dates; o Settlement Agreement Compliance Report for Section T – Sub Section I: Planning for Movement, Transition, and Discharge for 5/12 through 1/13; o For Individual #338, team meeting documentation in relation to her return to the Facility from a community placement; o Living Options ISPAs for the following: Individual #213, Individual #140, Individual #63, Individual #341, and Individual #231; o List of individuals transitioned to the community between 1/31/13 and 4/4/13; o Current Referrals for Community Placement, as of 4/4/13; o Resource Directory for community living options; o Individuals Not Referred – LAR Preference for Meeting Dates 6/1/12 to 1/31/13; o Individuals assessed for placement, date of assessment, and resulting recommendations, between 1/1/12 and 1/31/13; o Minutes from Regional Quarterly Meeting, dated 3/8/13; o CCSSLC Weekly Admissions Placement Coordinator (APC)/Transition Team Updates, from 12/17/12 through 3/25/13; o List of obstacles for individuals for whom 180 days had passed since their referral, undated; o Monthly ISPAs for the following individuals for whom 180 days had passed since their

	referral: Individual #26, Individual #169, Individual #74, and Individual #332; o Admissions and Placement Department New Employee Orientation Test, undated; o Discharge summaries and related assessments for: Individual #246, and Individual #78; o State Office review of the CLDPs for: Individual #71, Individual #341, and Individual #231; o CCSSLC Self-Assessment for Section T, updated 3/18/13; o Action Plan for Section T, revised 3/18/13; o CCSSLC Provision Action Information for Section T, undated; and o Presentation Book for Section T. ▪ **Interviews with**: o Esmerelda Vogt, Admissions Director; o Sandra Vera, Post-Move Monitor (PMM); o Laura Maldonado, Placement Coordinator; o Elena Martinez, Program Compliance Monitor; and o Rachel Martinez, QDDP Coordinator. ▪ **Observations of**: o ISP meeting for Individual #184; and o Post-Move Monitoring visit for Individual #213.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section T in conducting its self-assessment, the Facility: ▪ The Facility was using monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: 1) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 1 – Planning for Movement, Transition, and Discharge – Review of Living Options; 2) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Sections 1 and 4 – Planning for Movement, Transition, and Discharge and Alternate Discharges – Review of CLDP; and 3) Section T – Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs; Sub-Section 2 – Serving Persons Who Have Moved from the Facility to More Integrated Settings Appropriate to Their Needs – Review of Post-Move Monitoring. o Although these monitoring/audit tools included indicators relevant to the Facility's compliance with the Settlement Agreement, modifications had been made to the State's systems that were not reflected in the tools. An example of this was that changes had been made to the ISP Meeting Guide to structure the discussion about the types of obstacles teams discussed with regard to referrals and transition. Similarly, the State had set forth a specific process for teams to make independent recommendations to individuals and their guardians about potential transition to the community. These changes impacted the

	indicators included in the monitoring tools, but the tools had not been changed. In addition, not all requirements of the Settlement Agreement were included in the indicators the Facility had selected for inclusion in its Self-Assessment. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. o The monitoring tools did not identify adequate methodologies, such as observations, interviews, and record reviews to ensure that all of the staff responsible for auditing used the same methodologies. o Sample sizes were identified in the Self-Assessment. They were relatively small the Living Options component of auditing (i.e., based on interview and documentation provided, one living options monitoring tool was conducted monthly). Moving forward, the Facility should identify the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size) to provide a sense of whether or not they were representative samples. In addition, the Facility was only auditing the Living Options discussions for individuals that had been referred. This did not capture the entire universe of individuals for whom living options discussions needed to occur. o The monitoring/audit tools did not have adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. In the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team provided some specific comments on how these could be improved upon. o With regard to the staff/positions responsible for completing the audit tools, included a Program Compliance Monitor, the Admissions Placement Coordinator, the Post-Move Monitor, and Transition Specialists. o The staff responsible for conducting the audits/monitoring had not been deemed competent in the use of the tools. Although the staff responsible had some experience with developing ISPs, completing transition plans, and/or conducting post-move monitoring, no formal methodology was in place to ensure they were programmatically competent in the relevant areas. o Although based on the documentation provided, inter-rater reliability scores had increased, and were estimated at 100%, given the number of staff involved in auditing, it was unclear whether or not inter-rater reliability had been established between all auditors. In addition, the validity of the finding was questionable, particularly given the differences between the Facility's findings and the Monitoring Team's findings. ▪ The Facility was using some other relevant data sources, but was not yet using key indicators/outcome measures. For example, for Section T.1.b.2, which addresses education about community options, the Facility included numbers of individuals that participated in community tours, numbers of individuals and families participating in the Provider Fair, etc. However, in order for the data to be meaningful, such data should be put into the context of measurable outcome indicators. This would need to be accomplished by identifying baselines, and then setting a goal for what would be considered an acceptable or desirable level of participation. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically:

	○ Self-assessment activities did not consistently measure the quality as well as presence of items. For example, for Section T.1.g, the Facility found itself in compliance apparently because a report had been submitted to State Office on obstacles. Quality had not been taken into consideration. In the report, the Facility recognized that it had not collected the data required, but this was not reflected in the Facility's self-assessment of this requirement. Section T.2.a relates to post-move monitoring activities. From the metrics and narrative, it appeared the Facility only looked at the timeliness of the post-move monitoring activities, and not the quality of the monitoring or the follow-up activity, both of which were requirements of the Settlement Agreement. ○ At times, items that were being measured did not equate to compliance. For example, for Section T.1.b.3, the State Office requirement for assessment for appropriateness for placement required a number of steps that are detailed in the Monitoring Team's report. However, the Self-Assessment did not address these steps, but rather indicated the number of individuals in the sample that participated in their Living Options discussion, and the number a Living Options Monitoring tools completed for individuals referred. Neither of these in any way related to the State Office requirements related to assessment. ○ On positive notes, the findings generally were presented based on specific, measurable indicators, as opposed to overall compliance scores. ▪ The Facility rated itself as being in substantial compliance with the following sub-sections of Section T: T.1.c, which related to the development of CLDPs; T.1.c.1, which relates to the specifying actions in the CLDPs for the SSLC and coordination with providers; T.1.c.2, which requires specifying staff responsible and timeframes for completion of action steps in CLDPs; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.e, which relates to the inclusion of pre-move and post-move supports in CLDPs, and confirmation of the existence of pre-move supports prior to the individual's transition; T.1.g, which requires the development of an adequate report on obstacles to transition to the community; T.1.h, which requires the Facility to provide a Community Placement Report; and T.2.a, related to post-move monitoring. Not all of these findings were consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following sub-sections: T.1.c.2, T.1.c.3, and T.1.h. Largely, the discrepancies related to the Monitoring Team assessing the quality as well as presence of items. For example, T.1.g not only requires submission of an obstacles report, but submission of a report that is based on valid data, provides an adequate analysis of the data, and shows that the Facility and State have reasonably acted to reduce obstacles within its control. ▪ The Facility data identified areas of need/improvement. For these areas of need, the Facility Self-Assessment provided little to no analysis of the information, identifying, for example, potential causes for the issues. In addition, the Facility had not connected the findings to portions of the Facility's Action Plans or corrective action plans to illustrate what steps the Facility had taken to address the negative findings.
	Summary of Monitor's Assessment: Individuals' ISPs 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 ISPs provide a

	comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services, and that, as appropriate, these be transitioned to the community through the community living discharge plans. Although progress was noted with regard to the inclusion of recommendations in individuals' assessments related to their appropriateness for transition to the community, some assessments still did not include this information. In addition, although professional members of the team were making and documenting a joint recommendation in the ISP, sufficient justification for the recommendations often was not found, and/or reconciliation between the various team members' written recommendations was not documented. Teams continued to not fully identify obstacles to referral. As a result, the obstacles report submitted to State Office included limited data, and insufficient analysis. In addition, action plans to address obstacles were largely non-existent, and when they did exist, they were not individualized. In reviewing CLDPs, at least three individuals were returning to CCSSLC to attend the work center program. Presumably, this was due to the fact that similar services were not available to them in a community setting. As a result, they were not fully transitioned to the community from CCSSLC, but no obstacles to their fully transitioning to the community were identified. Community Living Discharge Plans continued to inadequately define the necessary protections, support, and services to ensure the individual's health and safety, and little progress had been made in this regard. Most of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports. Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. The Post Move Monitor's comments generally provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, for individuals moving to the community with more extensive medical and physical and nutritional support needs, there was a need for the Post-Move Monitor to have access to more clinical expertise. In addition, further work was needed to ensure the Facility and IDTs took action to correct deficiencies noted.

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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	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.1.a of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most	Noncompliance

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	criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	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 ISP. Since the issuance of this policy, the State had shared a revised draft policy with the Monitors. As noted in previous reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy, and on 5/16/11, had submitted comments for the State's consideration. At the time of the Monitoring Team's review of CCSSLC, the State had not yet finalized its revised policy. 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. However, numerous individuals (i.e., at the time of the review, approximately seven individuals) had not moved within the 180-day timeframe the State had established for itself. Various reasons were given for these delays. However, the Facility had not conducted an in-depth analysis to determine whether or not these delays were avoidable, and/or what actions could be taken to prevent ongoing delays. This was an ongoing problem, because during the last review, it was noted that six of 11 referred individuals had exceeded the 180-day timeline. As is discussed in further detail with regard to Section T.1.g, although obstacles to individuals' transition to community settings had not been fully identified and analyzed on a systemic level, anecdotally, the availability of community providers who could support individuals with complex behavioral and/or medical needs appeared to be an issue. The Monitoring Team agrees wholeheartedly with the teams' decisions not to transition individuals until an appropriate configuration of supports and services was identified. However, these were areas in which more systemic attention is needed from DADS State Office. Similarly, given that three individuals who had transitioned to homes in the community were returning to the Facility for vocational supports, supports were missing in the community that prevented individuals' full inclusion in options of their choosing. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
T1b	Commencing within six months of the Effective Date hereof and with	Since the Monitoring Team's previous review, the Facility had maintained its set of policies related to Section T of the Settlement Agreement. However, it was anticipated	Noncompliance

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	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:	that the State Office was going to issue an updated policy related to Most Integrated Setting that likely would require modifications to be made to Facility policies. As noted in previous reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy. Close to two years ago, on 5/16/11, the three Monitoring Teams had submitted comments on the DADS draft policy for the State's consideration. However, at the time of the onsite review, DADS had not yet issued a revised policy. The parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	
	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.	The specific requirements of this provision are discussed below, including: 1) the identification in the ISP 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 ISPs of Needed Protections, Services, and Supports</u> The first sentence of this provision states: "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." Based on an agreement of the parties, substantial compliance with the first sentence of this provision equates to substantial compliance with the following provisions of Section F: Section F.1.d, which requires Facilities to 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; Section F.2.a.1, which requires ISPs to address, in a manner building on the individual's preferences and strengths, each individual's prioritized needs; and Section F.2.a.3, which requires ISPs to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. As noted above with regard to Section F of the Settlement Agreement, although CCSSLC had continued to make efforts to improve ISPs, the Facility remained out of substantial compliance with Sections F.1.d, F.2.a.1, and F.2.a.3. Additional details are provided in the sections of this report that address these provisions.	Noncompliance

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		As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs 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 ISP will be the key document that is used to ensure that pre-move required supports are identified and in place prior to an individual's move, and post-move required supports are identified and provided in a timely and complete manner. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> The revised ISP format included a section on obstacles the IDT identified. It included the State Office's standardized list of obstacles to community referral to assist in the analysis of information collected from IDTs throughout the SSLC system. The State Office had developed a more detailed list of obstacles that teams would use should issues arise as they made efforts to transition individuals to the community. In reviewing the sample of seven ISPs, teams generally had identified some obstacles. Of the seven ISPs reviewed, six should have had obstacles defined. The remaining individual had been referred for transition to the community (i.e., Individual #59). Of the six remaining plans, one (17%) included an adequate list of obstacles (i.e., Individual #111). The problems associated with the remaining lists of obstacles included the following: ▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were (e.g., Individual #279 for whom no subcategory was selected, and the ISP provided no insight into the guardian's specific concerns, and Individual #58) or the full set of the concerns were not identified on the list in the ISP (e.g., for Individual #298, the team identified the guardian and individual's reluctance as obstacles, but in the subcategories did not identify prior unsuccessful community placements, which the narrative of the ISP identified as an issue). One of the problems was that the list of concerns from which teams could choose was not comprehensive enough. For example, as discussed in further detail below, at an ISP meeting observed, the guardian provided a list of concerns impacting her choice that Individual #184 remain at	

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		CCSSLC, but most of these concerns were not available options on the list in the ISP; ▪ At times, the team, independent of the individual and guardian, did not recommend transition to the community. However, no obstacle beyond individual or guardian choice was selected. If the team's independent recommendation was for the individual not to transition, then another obstacle should have been identified (e.g., Individual #58, and Individual #311); and ▪ Some were not adequately justified (e.g., for Individual #301, the obstacles the team identified included "Individual choice - lack of understanding of community living options," and "medical issues." The specific medical issues and/or supports not available in the community to address his medical needs were not identified anywhere in the ISP. He was not able to or had not expressed a choice, so it was unclear why that was identified as an obstacle). Moreover, action plans to overcome the obstacles identified generally were not adequate. Of the six ISPs, two (33%) included an action plan to overcome obstacles identified (i.e., Individual #). Of these two, none (0%) were adequate. The plans were not adequately individualized or measurable (e.g., for Individual #301, his ISP included a plan to have him continue going on group home tours, but the plan was not individualized to address either of the obstacles the team identified, or to provide additional educational opportunities; and for Individual #279, the only action item in the ISP related to community transition was to invite the guardian to the provider fair. Given that this was the plan last year, and it did not work, it was unclear why it was included again. In addition, because little information was included in the ISP about the reason for the guardian's opposition, the adequacy of the plan in addressing the reason for her reluctance could not be determined.). As has been noted previously, when a guardian is reluctant, to the extent possible, the related action plans should address the specific issues about which the guardian is concerned. For example, if the guardian were concerned about the behavioral supports available in the community, then more education or research about the individual's options for being properly supported would be appropriate topics for an action plan. Sometimes, the action plans will involve staff action as opposed to guardian action. The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports. The Facility had begun to collect information on the obstacles to individuals' transition to the community. However, this appeared to be in the initial stages. Despite the fact that at the time of the review, seven individuals had exceeded the State-determined 180-day timeline for transition, and this had been an ongoing problem for a number of individuals	

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		throughout the year, only five obstacles to transition were included in a summary report the Facility provided. For two individuals, the obstacles were noted to be lack of availability of specialized medical supports. For two, it was noted that they had not found a home that suited them, and for one, the time needed to gradually acclimate to the community was the obstacles identified. It was unclear what the obstacles had been for other individuals, who had transitioned, but for whom it had taken longer than 180 days, or for the others currently in the transition process. It also was unclear if there were obstacles for individuals who had not exceeded the 180 days. In addition, in reviewing CLDPs and post-move monitoring reports, at least three individuals were returning to CCSSLC to attend the work center program. Presumably, this was due to the fact that similar services were not available to them in a community setting. As a result, they were not fully transitioned to the community from CCSSLC, but no obstacles to their fully transitioning to the community were identified. Since the last review, no progress was seen in identifying or addressing obstacles to referral. CCSSLC remained at the beginning stages of adequately identifying obstacles to community transition, and developing plans to overcome any of the obstacles identified. These deficiencies, in addition to ISPs 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 had 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, but work was still needed to ensure adequate education was provided. The following summarizes the actions taken as well as areas in which additional work was needed: ▪ **Annual provider fairs**: Since the last review, the annual provider fair was held on Saturday, 10/27/13. A Committee had worked to organize the fair, and decided on a Halloween theme. Members of the Self-Advocacy Group had participated in the planning. A creative addition this year was the display of individuals' collages of their "ideal home." The Monitoring Team saw the submissions, and they were quite impressive. Staff were looking into having them displayed on campus. Based on data provided and the census of 252 individuals and 897 staff, participants at the October fair included 65 individuals (26%), four family members (i.e., all family members for one individual), 75 staff (8%), and seven HCS providers. These data were summarized in a chart, and some analysis had been conducted. The Admissions Placement Department had made efforts to	Noncompliance

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		increase family participation, and had hoped a Saturday fair would help. For example, the Volunteer Services group provided a $20 gift card to reimburse families for expenses. Active treatment staff assisted individuals to make and send invitations to their families. The fair was advertised in the Facility's newsletter. However, based on the outcome, these efforts did not attract additional family members. Another factor that impacted attendance of individuals and staff was inclement weather. Based on the information provided, it did not appear that outcome measures had been established with regard to attendance and/or satisfaction. Review of such data from year to year would be important to allow the Facility what was working and not working, and to determine whether changes needed to be made to future provider fairs. ▪ **Education about community options:** Individuals and their guardians also were provided information through the following: o Based on review of ISPs, the Local Authority CLOIP process appeared to have occurred regularly as part of the individual planning process. However, it did not appear that outcomes/measures had been determined and/or data collected regarding the number of individuals and families/LARs who agreed to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refused to participate in the CLOIP process. Collection and review of such outcome data would allow the State to evaluate the effects of the process and make changes made to future educational activities. o Since the last review, the Transition Specialists had developed a Resource Directory. For each of the providers in the area, some basic information had been collected about the provider, as well as each of the homes/programs the provider supported. In many cases, pictures of the homes were available. Each SSLC was developing a similar Resource Directory, so ultimately such information should be available for counties around the State, and reportedly the various directories were being made available electronically. This was a positive development, and should provide teams with another tool to educate individuals and families/guardians about available options. ▪ **Tours of community providers**: Based on data the Facility provided, it appeared that tours were occurring regularly (i.e., most Fridays). However, without calculating the raw data, it could not be determined with any certainty how many individuals participated, how many locations individuals had visited, or the size of the groups that went on visits.	

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		It was unclear if Facility staff had analyzed the data to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individuals' specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. ▪ **A plan for staff to learn more about community options**: In the Facility's action plans, it had included part of a plan to train staff. Specifically, the plan addressed QDDPs, Psychologists, nursing staff, Habilitation Therapists, and vocational services staff. Those not specifically included in the plan included: management staff, other clinical staff, and direct support professionals (except at New Employee Orientation. A formalized plan should include these additional groups of staff. Through sign-in sheets and logs, it appeared staff participation in various training opportunities was being tracked. However, it was not clear if data regarding staff training were being aggregated and analyzed. However, the Facility had continued to take a number of steps to provide educational opportunities to staff. Some of the examples of training for staff that the Facility had documented included: o Staff participation in CLOIP tours was continuing, and a log tracked dates on which staff participated, and their titles. An unduplicated count of staff involved in these tours was not included in the documentation provided. o Beginning in September 2012, the Admissions Placement Department began providing training as part of New Employee Orientation. At the time of the Monitoring Team's review, the curriculum was under review and revision. However, it was positive that from the time of orientation, staff were exposed to the transition process and community alternatives. o On 3/5/13, staff from DADS State Office provided training to staff, including training on Living Options, the community transition process from a SSLC, the Support Spreadsheet, pre-move and post-move supports, and obstacle categorization. A total of 74 staff attended the training, including all of the QDDPs, and a number of staff from a variety of disciplines. o In January 2013, training was provided on the CLOIP process. Approximately 58 staff attended. o In July 2012 and September 2012, a Home and Community Based Services presentation was offered for the residential units. A member of the one of the Local Authority's staff made the presentation. o Transition Specialists were supposed to begin attending one ISP meeting per week. This should be helpful in further educating teams, as	

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		well as individuals and families about options. ▪ **Opportunities to visit friends who live in the community:** The Facility should provide opportunities for individuals to visit friends who live in community; ▪ **Individuals and families have opportunities to learn about success stories:** The Facility had not yet addressed the following areas adequately: o The Facility should include success stories about individuals in newsletters or other forums, and/or have individuals or their guardians present information about their experiences in other forums (e.g., Family Association meetings, provider fairs, or small group settings); o As appropriate, the Facility should pair families/LARs who have experienced a successful transition with families/LARs who are reluctant; and o If aggregate data showed that families and guardians had similar concerns, then the Facility should use mechanisms to provide information on specific topics. For example, offering specific educational seminars might be useful. ▪ **Education may be provided at Self-Advocacy, house, and Family Association meetings, or other appropriate locations:** Based on documentation provided, a member of the Admissions Placement Department had presented at the Family Association meeting on 12/8/12. In addition, a Transition Specialist had presented at the Self-Advocacy meetings in August 2012 and September 2012. It did not appear that the Facility was currently engaging in educational during house meetings. ▪ **Regular SSLC meeting with the Local Authority:** Based on interview with staff, meetings with staff from the Local Authorities had begun to occur. In addition to staff from CCSSLC attending the quarterly meeting the local authorities had with providers, in March 2013, CCSSLC also had had one quarterly meeting with staff from the Local Authority, and planned to continue these meetings. Based on minutes, this involved six different Local Authorities. Relevant topics were discussed, including coordination between the Facility and Local Authorities, as well as CLOIP tours and the provider fair. ▪ **Individualized Plans:** The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing seven recently completed ISPs, one individual had been referred to the community. For the remaining six, two (50%) had a plan that addressed education about community options. However, none of these (0%) were adequately. The following concerns were noted: o None of the plans were individualized to address the individual and/or the LAR's particular needs or concerns (e.g., for Individual #301, his ISP included a plan to have him continue going on group home tours, but	

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		the plan was not individualized and did not provide additional educational opportunities; and for Individual #279, the only action item in the ISP related to community transition was to invite the guardian to the provider fair. Given that this was the plan last year, and it did not work, it was unclear why it was included again. In addition, because little information was included in the ISP about the reason for the guardian's opposition, the adequacy of the plan in addressing the reason for her reluctance could not be determined.). The action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals' or their guardians' questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans using the information that the team is able to gather about the reasons for the individual, family member, or LAR's reluctance. For example, if an LAR has questions about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. At the time of the review, this had not yet occurred. Creative ideas and brainstorming within CCSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. o The plans could be measured in terms of whether or not the limited activities described occurred. However, neither provided for the team's follow-up to determine the individual or guardian's reaction to the activities offered. No methodologies were included to ensure that the individual and/or guardian's questions were answered (e.g., helping them write a list of questions specific to them, or a staff person assisting with asking questions). The action plans generally provided for the team to provide ongoing monitoring, but no specific strategies were included to obtain the individual's reaction at the time or shortly after an educational opportunity. o As noted above, both plans continued identical activities from the year before. The plan for Individual #279 was identified as unsuccessful the previous year, but the team continued the same plan. Based on the information included in the ISP, it was difficult to determine whether or not the plan for Individual #301 was successful. o The following individuals had no plan for further education: Individual #111, Individual #298, Individual #311, and Individual #58.	

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		Although the Facility was continuing to complete some of the basic activities related to education, minimal progress had been made since the last review in individualizing the process. Although some individuals had a plan in their ISPs, the plans generally were not individualized. The individualization of this process is key to ensuring that individuals and their guardians are provided education that allows them to make an informed choice, as required by the Settlement Agreement. Other areas in which focused efforts were needed included supporting individuals to visit friends in the community, and providing individuals and families with opportunities to learn about success stories. Further work was needed in analyzing data and addressing issues identified. The Facility remained out of compliance with this provision.	
	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.	Since the last review, in assessments prepared for annual ISP meetings, improvement was seen in the inclusion of the assessor's recommendation regarding transition to the community. Some assessments still did not include such recommendations. In addition, based on review of a sample of ISPs, ISPs generally included a summary or conclusion with regard to the professional team members' joint determination or recommendation with regard to whether or not community placement was appropriate. However, many concerns were noted with regard to the justifications teams provided for their recommendations, and in relation to the lack of reconciliation between recommendations included in the assessments and the final recommendation. Based on a review of seven ISPs (including those for Individual #58, Individual #311, Individual #279, Individual #301, Individual #59, Individual #298, and Individual #111), the following was found: ▪ Of the seven ISPs reviewed, for four individuals (57%), all of the assessments included the applicable statement/recommendation. All assessments for Individual #301, Individual #279, Individual #311, and Individual #58 included a recommendation. For Individual #59 and Individual #111, only the Functional Skills Assessment did not include a recommendation. ▪ Of the seven ISPs reviewed, one of the individuals had been referred for transition to the community. For the remaining six individuals, six individuals' ISPs (100%) included a recommendation from the professionals on the team to the individual and LAR. However, for only one of these individuals (14%) was adequate justification provided (i.e., Individual #279, whose team recommended transition, but the guardian chose not to pursue transition). The following provide explanations of inadequate justification for teams' conclusions: o Based on the ISP for Individual #58, the PCP, SLP, and Nurse recommended against community living. From the ISP, it was unclear what the other team members recommended. In the section of the ISP in which the overall team recommendation independent from the individual and guardian was documented, these three team members	Noncompliance

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		were again cited as making the determination that Individual #58 "would not benefit from moving to a less restrictive environment at this time." No reason or justification was provided, and it remained unclear what the rest of the team recommended. This was concerning given that in their assessments other team members (e.g., Psychology, OT/PT, dental, vocational, and the FSA) had indicated he could be supported in a less restrictive setting, but no mention of this was made in the ISP. The ISP also appeared to be inaccurate, because in the SLP's assessment as well as the nursing assessment, the assertion was made that he could be supported in a less restrictive environment. Based on the medical assessment, the PCP appeared to have a concern about a particular health issue that was currently under review, but this was not further explained in the ISP. However, in the assessment, the audiologist indicated that his behaviors "mitigate against community placement." o The ISP document for Individual #311 indicated that except for OT/PT, all team members' assessments indicated he could be served in a less restrictive setting. However, during the team discussion: "the team noted that while he may be able to be served in a less restrictive setting, [Individual #311] does not respond well to change and has a history of failing health when his environment changes. The team agreed it could be detrimental to [Individual's] physical and emotional health initiate [sic] a change from his current living environment. The team agrees it would be beneficial for [Individual] to remain at CCSSLC." The team did not reconcile the recommendations in the assessments with this conclusion, and provided no justification for its joint recommendation (i.e., a description of the history related to changes in environment and failing health), nor did the team appear to consider the possibility of a slow transition process. o Individual #301 did not have a guardian, and was unable to communicate his decisions. His team recommended that he not be referred for transition to the community with the following justification: "…as noted by [Individual's] medical team, he has serious respiratory problems and his seizures have intensified recently. These medical concerns at present mean he needs time to stabilize medically before a referral to the community can be reconsidered." However, all assessments had statements indicating that assessors believed he could be supported in a less restrictive environment. No explanation was provided regarding how all the team members changed their minds during the ISP meeting. o The team indicated in the ISP that the "facility discipline members (independent of the resident and LAR/family) determined that	

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		[Individual #298] would not benefit from moving to a less restrictive setting." However, the reason they provided was that it was her request to remain at CCSSLC, and her father/guardian would like her to remain there. As a result, this was not an independent recommendation, but a recommendation based on the individual and guardian's wishes. Moreover, it was not consistent with the statements in the team's assessments, and no justification was provided for team members' changes in opinion about her appropriateness for a more integrated setting. Most assessments included a statement about her appropriateness for a more integrated setting, except for the psychiatric and vocational assessments. Most said that she could be supported in a less restrictive setting. The exceptions were audiology in which the assessor indicated that there were no audiological contraindications, but "there may be sufficient other reasons due to the complexity of this resident's care that community placement is not desirable." However, no specific reasons or complexities were delineated. The FSA indicated no barriers existed, but the guardian wanted her to remain at CCSSLC. Again, this did not represent an independent recommendation. o For Individual #111, the majority of assessments indicated he could be supported in a less restrictive setting, except for the psychology, medical, and psychiatric assessments. The psychological and psychiatric assessments were both approximately a year old. All three of these assessments referenced his recent admission and/or failed community placement due to his behavioral issues as the reasons. The team made an independent recommendation, but it was not adequately justified. Specifically, the team indicated that he continued to require more structured programming. However, no justification was provided such as data related to his behaviors, or any indication of why the team believed such structure could not be provided in a community setting. In addition, the ISP provided no reconciliation regarding the many assessments that indicated he could be supported in a less restrictive setting with those that did not. During the onsite review, the Monitor observed Individual #184's ISP meeting. The Local Authority staff was not present for the entire discussion about Living Options. The QDDP summarized for the group that all of the individual's assessments, except the medical assessment, indicated Individual #184 could be supported in a less restrictive setting. No further information was provided about the PCP's specific concerns, and the PCP was not present at the meeting. The guardian was opposed to a referral to the community. Although some team members (i.e., Habilitation Therapy staff, and the Program Coordinator) attempted to provide additional information about community options that	

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		might support his needs, the team, independent of the individual and guardian, never overtly made a recommendation to the guardian and individual, or reconciled the difference of opinion between the PCP and other assessors. This was a challenging situation, given the guardian's clear reluctance to even consider group home tours for the individual. However, some team members made statements such as community placement "would not be beneficial for him, and might be detrimental." The team's assessments did not support this statement, and no justification was provided for this in what the team discussed concerning his supports at the Facility. Moreover, beyond the guardian's concerns (i.e., stability of staff at the Facility, Individual #184's long tenure at CCSSLC, experiences of seeing individuals from group homes in local stores, etc.), the one reason that the team discussed for not making a referral was that Individual #184 liked to wander around campus, and this behavior would not be safe at a group home. In other words, by living at CCSSLC, Individual #184 had become used to practices that were not normalized (i.e., moving around in his wheelchair on a campus where typical rules of the road were not followed). His tenure at the Facility had made it more difficult for him to live in an integrated setting. Also of concern, the team did not recognize the significant issue this posed, and/or develop a specific plan to address it and/or reduce it as an obstacle to community transition. Ultimately, at the request of the current guardian, the team agreed to defer discussion until a potential successor guardian could be involved. The Facility remained out of compliance with this provision. Although progress was noted with regard to the inclusion of recommendations in individuals' assessments related to their appropriateness for transition to the community, some assessments still did not include this information. In addition, although professional members of the team were making and documenting a joint recommendation in the ISP, sufficient justification for the recommendations often was not found, and/or reconciliation between the various team members' written recommendations was not documented.	
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:	Since the last review, limited, if any, progress had been made with regard to CCSSLC teams' development of CLDPs. None of the CLDPs were yet adequate to ensure individuals had appropriate protections, supports, and services to meet their needs once they transitioned to the community. It was concerning that the Facility's Self-Assessment indicated that it was in substantial compliance with all subsections of Section T.1.c, as well as with Section T.1.e. This showed a lack of understanding of the Settlement Agreement requirements related to Community Living Discharge Plans. Community Living Discharge Plans were reviewed for five of the nine individuals who had transitioned from the Facility to the community since 8/1/12, representing 56% of this group of individuals. These included the CLDPs plans for Individual #140, Individual #231, Individual #63, Individual #213, and Individual #341. The Monitoring Team also briefly reviewed the CLDPs for Individual #71, Individual #62, and Individual #208.	Noncompliance

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		They evidenced the same problems and issues discussed below for the individuals included in the sample. With regard to the timeliness of the Community Living Discharge Plans, four of the five (80%) included documentation to show that they were developed sufficiently prior to the individual's transition. The plan that did not include such documentation (Individual #140) appeared to have been developed only two weeks prior to the individual's transition. The documentation in the body of the CLDP indicated that some planning, including visits to providers had occurred over the months prior to the CLDP meeting date. It was unclear, though, what had happened in the intervening months. The Facility had added information to the face sheet of the CLDP to identify when the plan first was initiated, and each date on which it was revised. Dates documented on the top of the first page for this individual did not show planning prior to the month in which she transitioned to the community. For the remaining plans, the initiation dates were generally close to the referral date (i.e., with the exception of Individual #231), and many revision dates were noted. This was a positive development. The Facility remained out of compliance with this provision.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, none of the five 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. Very similarly to the last review, some examples of the general concerns noted across all plans included: ▪ Many of the plans identified the need for training for community provider staff. However, none of them adequately defined 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, even when assessments identified the need for this, such as in relation to Individual #140's PBSP). ▪ Except for one exception, plans 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 ISPs should be targeted for more intensive training of community provider staff, or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual. The one exception to this was a	Noncompliance

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		rather vague pre-move support for Individual #213 that read: "Provider staff to complete competency based training at CCSSLC by Habilitation Therapies." Although it was positive that competency-based training was required, it was unclear specifically what the training would include. ▪ Missing from most of the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care. In a couple of the plans reviewed, action steps were included for the CCSSLC nurse to meet with the community provider nurse. This was positive, however, not necessarily well defined. However, for other clinicians, such as the psychologist/behavior analyst, psychiatrist, physician, habilitation therapists, etc., no such action steps were included. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff. ▪ None of the plans described CCSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Psychology Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment). ▪ None of the plans addressed any role that CCSSLC staff or community provider staff might play in assisting the individual to make the transition. For example, there appeared to be no consideration about the need for CCSSLC staff to follow the individual into the community for any period of time (e.g., the first day or longer), or to check in by telephone on occasion. Likewise, no action steps were provided in any of the CLDPs for community provider staff to visit the individual at CCSSLC. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible. One clear example of this was Individual #231. His CLDP stated: "[Individual] would need to establish a solid relationship with staff due to the fact that he has some anxiety and would need to feel comfortable around them and learn to trust them." Further evidence of this was seen in the team's ongoing concerns throughout the transition process of an exacerbation of his psychiatric symptoms when he conducted tours of potential homes, including the addition of an anti-anxiety medication. However, no supports were included in his CLDP to assist Individual #231 with becoming familiar with the new staff with whom he would be working, or bridging his transition through ongoing contact with familiar staff at CCSSLC.	

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		▪ The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of pre-move and post-move supports. As is described in further detail in the section of this report that addresses Section T.1.e of the Settlement Agreement, the CLDPs also did not consistently identify the other pre-move and post-move supports required by the individuals. The Facility remained out of compliance with this provision.	
	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. Teams also had continued to consistently identify the specific person(s) responsible by name and/or position for action steps included in CLDPs for which Facility staff or others were responsible. Such details were found in all five of the plans reviewed (100%). The Facility was found to be in substantial compliance with this provision. As noted in previous reports, in order to remain in compliance, the Facility is cautioned to ensure that as the supports included in CLDPs expand that adequate timeframes and persons responsible are assigned. For example, implementation of plans, such as PNMPs, health care plans, and PBSPs, will require a start date, and then a frequency to be stated for a number of different aspects of plan implementation (e.g., daily implementation and documentation, monthly review by a clinician, at least annual review or as needed modifications to the plan, etc.). This will require a lot more detail regarding both timeframes and persons responsible.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Based on review of five CLDPs, all six (100%) included documentation that the plans had been reviewed with the individual and/or the LAR.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports	As the Monitoring Team has noted in previous reports, issues existed with regard to both the availability of assessments, as well as their quality. In other sections of this report, the Monitoring Team has commented on transition assessments. Consistently, the Monitoring Team found them to be inadequate to provide the IDTs with adequate information with which to develop an appropriate CLDP or to offer community providers	Noncompliance

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	within 45 days prior to the individual's leaving.	the information necessary to ensure a safe and successful transition for the individual. The following information is repeated here from Section M and exemplifies the issues related to inadequate assessment processes for individuals transitioning to the community. Regarding the nursing documentation for discharges/ individuals transitioning to the community since October 2012, a review of the nursing notes and Nursing Discharge Assessment Summaries for all nine individuals including: Individual #213, Individual #341, Individual #71, Individual #62, Individual #208, Individual #63, Individual #140, Individual #231, and Individual #69 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would specifically guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%) of the individuals. No IPNs were provided in response to the following document request for any of the nine individuals transitioned to the community: "For the past six months, nursing documentation for individuals who have transitioned to the community, including but not limited to the completed nursing discharge summary, progress note, and the comprehensive nursing assessment." ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed. With regard to tracking the availability, timeliness, and quality of assessments: ▪ For none of the five CLDPs reviewed (0%) were all assessments provided in a timely manner. For all five individuals, one or more assessment was submitted after the final community living discharge plan was developed. Some were dated the day of the individual's transition to the community. It was unclear what, if anything happened to update the CLDP with the assessment information, or make needed changes to pre-move or post-move supports. For example, the great majority of Individual #231's assessments were dated after the date of the CLDP. Many of Individual #140's assessments were dated the day of or after the CLDP. In addition, for some individuals, assessments were missing (e.g., psychiatric assessments for Individual #341, and Individual #63, and medical assessments for Individual #231, and Individual #140). In addition, for some individuals, the 45-day requirement had not been met (e.g., for Individual #213, the majority of the assessments had been completed more than 45 days prior to the individual's transition to the community). ▪ In addition, the quality of these assessments was lacking. None of the six CLDPs reviewed (0%) were based on adequate assessments. In particular:	

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		o Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. Such a summary should contain an analysis of information, not merely a listing of dates, times, occurrences/lab results, etc. o In addition, assessments frequently were inadequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. They did not describe or recommend the protections, treatments, and supports that needed to be provided (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.). o Moreover, assessments did not identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. o In addition to specific issues related to transition, as is discussed in other sections of this report, the underlying assessments were not of adequate quality. o Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to 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.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information.	

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		In addition to significant quality issues related to the assessments available, there continued to be assessments that were not updated, or were updated after the individual's CLDP was finalized. The Facility remained out of compliance with this provision.	
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 pre-move and post-move supports. Since the last review, little, if any, progress had been made in expanding the scope of protections, supports, and services identified in the CLDPs. On a positive note, across the State, changes were being made to ISPs. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. The current format of identifying the full array of supports after the individual was referred for transition made it more difficult due to the generally short timeframes from referral to transition. Of significant concern, however, was a trend seen in this review of not including many supports that were in individuals' ISPs, including their IHCPs and/or risk action plans, in the CLDPs. It was not clear that teams had used these documents as the basis of the CLDPs, and identified how supports would be transitioned to community settings. As ISPs improve, it is essential that teams use them as the basis for the CLDPs. At the time of the current review, teams did not consistently identify all the pre-move or post-move supports that the individual needed to transition safely to the community, nor did teams adequately define the pre-move 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. In none of the five plans reviewed (0%) was a comprehensive set of pre-move and post-move supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. Similarly to the last report, the following summarizes the general concerns noted: ▪ Generally, teams were not visualizing the individual with no supports at all, and then identifying each and every support that was needed to assist the individual to be successful in a particular community environment(s). Due to the current inadequacies of the ISPs, teams needed to start at the beginning, and describe the full array of supports the individual needed and wanted. Once these were listed, the CLDP needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. This could only be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this	Noncompliance

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		knowledge, the foundation for the CLDP could be built. ▪ Although clinical services (e.g., nursing, psychology, therapy, etc.) were sometimes now referenced in the CLDPs, they still often were missing. Sometimes, the qualifications of staff were identified (e.g., for Individual #140, her CLDP identified the need for a BCBA to review her PBSP, as did Individual #341's CLDP). However, this was not consistent across CLDPs. In addition, the intensity of the supports was not identified. Supports defined as "be seen by a psychologist to monitor BSP and behaviors," or "Establish with a Dietician" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at CCSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community. ▪ In addition, clinical supports that CCSSLC was providing, based on assessment information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care/health management plans often were not referenced in the CLDPs reviewed, or were simply referenced as something the CCSSLC nurse would review with community provider staff, not as plans that required implementation. Likewise, individuals who were receiving habilitation therapies supports at CCSSLC did not have functionally equivalent supports identified in their CLDPs. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans/IHCPs that the Facility had begun to develop, albeit still inadequate, were not adequately reflected in action plans included in the CLDPs. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. Based on this most recent review, CLDPs included some of the action steps, but none of the CLDPs reflected even all of what was in the CCSSLC inadequate risk action plans. Often multiple steps related to the multiple risks that each of the five individuals had were not transferred into the CLDPs. As just one example, Individual #213 had multiple medium and high-risk ratings, as well as low risk ratings for which interventions were needed. Although his risk action plans at CCSSLC did not comprehensively address his needs, they did include a number of interventions that were not transitioned to the community provider through the CLDP. Some were, but the great majority of the risk action plan interventions were not. This placed him at significant risk. ▪ In removing any support that the individual utilized at the Facility from the array of support that would be provided in the community, teams should justify	

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		why the support is not needed in the community. For example, for individuals with health management plans at the Facility, their discontinuation would need to be justified, or an alternate support provided. Similarly, if individuals receive supports from Psychology, Habilitation Therapies or Dietary at CCSSLC, these services should be included in the CLDP, unless justification is provided for not including them, or an equivalent community service is identified. In a couple of instances (i.e., Individual #140 and Individual #231), anger management training was discontinued. This appeared to be related more to what was perceived to be available in the community, as opposed to what was most effective for the individual. For Individual #231, when the community provider stated that these services were not available, even though he was moving to a large metropolitan area, the team allowed an alternative to be put in place. For Individual #140, the team provided no specific reason for discontinuing the specific training, but indicated it could be picked up by the BCBA or licensed counselor. Without further commitment in the CLDP regarding how these supports would be configured, this did not appear to be an equivalent to what the individual received at CCSSLC. Another example of this was for Individual #63 who had significant weight issues that placed him at risk. At CCSSLC, he had an IHCP, albeit inadequate, that included a number of steps to address his weight. The only supports in the CLDP related to this were: "Establish with dietician," and to train undefined staff on the IHCP. No post-move supports were included to require the new provider to implement the IHCP, maintain his diet, assist him in engaging in exercise, etc. No justification was provided for discontinuing these supports that CCSSLC had provided. ▪ Teams were not factoring in modifications that needed to be made to current programs or plans, and writing this into the pre-move or post-move supports. As one example, when an individual who has a Behavior Support Plan that uses campus bucks as a reinforcer moves to the community, plans need to be put into place to transition the individual to a different reinforcer. One of many examples related to Individual #231's PBSP. The psychologist clearly indicated in the assessment that an incentive program should be established in the community, but this was not included as a pre- or post-move support. Individual #63 was using campus bucks as a reinforcer, but no plan was included in the CLDP to transition this to a realistic alternative in the community. ▪ Often plans required that community staff be trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training, as well as the scope of staff trained. ▪ In addition, few, if any, plans identified post-move supports for the full set of plans implemented at the Facility (e.g., nursing care plans, health management plans, PNMPs, and PBSPs) to be implemented in the community. ▪ Many of the individuals reviewed had specific health care indicators that needed	

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		to be monitored and reported (e.g., constipation, input/output, seizures, weight, meal refusals, psychiatric symptoms, etc.). However, few, if any supports were included in the CLDPs to ensure that specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff. With the most recent plans, more action steps were seen for monitoring some of these indicators, but consistently not all were identified, and when they were, no parameters for notification or next steps were identified (e.g., Individual #341's blood glucose and blood pressure checks, Individual #63's blood sugar, and numerous clinical indicators for Individual #213). ▪ None of the plans identified the need to develop crisis intervention plans. As a result, it was unclear how the current methods for dealing with crises at the Facility would be modified in a community setting. Clearly, a number of individuals that transitioned had histories that would indicate the need for solid crisis intervention planning, but this had not occurred. As one example, Individual #63 had been admitted to CCSSLC within the last year due to extensive behavioral issues that resulted in his arrest, and repeated interaction with the court system. No plan for addressing crises should they occur was included in his CLDP. ▪ Direct support staffing ratios and requirements (i.e., supervision level) generally were not specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). ▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., specific medical follow-up, adherence to weight reduction programs, etc.). ▪ Generally, day and vocational supports were not well defined. One of many examples related to Individual #231. His team indicated work was important for him, but the only supports included in the CLDP involved transferring his DARS referral to the area in which he would be living, and a post-move support to "Establish employment." The provider was given 90 days to establish employment, and no day/vocational supports were included for the intervening 90 days, nor was any plan in place should employment not be found within this time period. Almost identical issues were noted with regard to Individual #341's CLDP, but even less specific requirements were included for actually assisting the individual to find employment. ▪ Supports that needed to be provided across day and vocational programs, as	

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		well as residential programs (e.g., nursing, psychology, therapy, etc.) generally were not included as part of the day/vocational component. ▪ Issues continued to be noted with regard to the measurability of supports identified. Although this had improved, the issue was not completely resolved. ▪ It appeared that teams often were identifying due dates for critical supports that were not reflective of what the individual needed, but rather dependent on issues related to the conversion of individuals' Medicaid from institutional to community Medicaid. Not having such supports available at the time of transition, or shortly, thereafter potentially compromised individuals' successful transition. As one example, Individual #213 had a number of medical complexities that could have required medical intervention at any time. However, his CLDP provided 30 days for the community provider to: "Establish [him] with a PCP." With regard to Monitoring by the Local Authority or other means to ensure pre-move supports are in place prior to an individual's transition, the Local Authority's review appeared to be a general safety assessment as opposed to an individualized assessment based on the pre-move supports identified by the team. The only assurances that the Local Authority staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the pre-move 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 <u>could be</u> 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 pre-move services required by the CLDPs were in place. None of these forms, for the sample reviewed, provided any additional documentation to show that the Local Authority representatives had actually confirmed that the individualized pre-move supports were in place. However, the Facility was having the Post-Move Monitor conduct a pre-move site visit designed specifically to determine if the pre-move supports were in place. A review was conducted of nine individuals' pre-move site visit documentation (i.e., Individual #231, Individual #69, Individual #208, Individual #62, Individual #71, Individual #341, Individual #63, Individual #213, and Individual #140). All nine (100%) appeared thorough, and included each pre-move support listed in the individual's CLDP. They identified the evidence that had been reviewed to determine that the pre-move support was in place. They also appeared to have been completed in a timely manner, a couple of days prior to the individual's transition. The process will become more complicated as	

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		more pre-move supports are appropriately identified in individuals' CLDPs. As noted in the previous report, 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 confirmation of pre-move supports, substantial work was still needed in adequately delineating the pre-move and post-move supports in individuals' CLDPs.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Areas in which progress had been sustained included: ▪ The Facility was conducting monitoring using the tools that had been modified based on the Monitoring Teams' audit tools. Both the QA Department and the Admissions Placement Department were responsible for conducting reviews. ▪ Although based on the documentation provided, inter-rater reliability scores had increased, and were estimated at 100%, given the number of staff involved in auditing, it was unclear whether or not inter-rater reliability had been established between all auditors. In addition, the validity of the finding was questionable, particularly given the differences between the Facility's findings and the Monitoring Team's findings. In other words, if both auditors were incorrect in their assessment of an indicator, high inter-rater reliability would be present, but the data still would not be valid. ▪ The Facility also had developed a user-friendly format for displaying the results of monitoring activities. It provided a printout of the results of each indicator, which could be viewed over a period of months, allowing comparisons to be easily made. ▪ The Facility had continued to incorporate the data into its self-assessment. Areas in which continued efforts needed to be made included: ▪ As noted above, inter-rater reliability needed to be established between all auditors. ▪ The accuracy of the monitoring data was questionable. ▪ The Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring. ▪ An important part of quality assurance for Section T will be review of the outcome data for individuals that transition to the community. Analysis should include review of supports that might have prevented negative outcomes, and a determination of whether or not such supports were included in CLDPs, as well as whether or not community providers provided the necessary supports. The Facility provided data on 13 individuals that had transitioned to the community between 2/23/12 and 1/24/13. Additional information was gained through	Noncompliance

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		interview and documentation review with regard to two other individuals, one of whom had transitioned from CCSSLC to the community in 2010, and another in 2011. Of these 15 individuals, a total of five individuals experienced negative outcomes: o A total of three individuals had returned to a SSLC. Of these: ▪ One returned to CCSSLC at the guardian's request after increasing behavioral issues made it difficult for her to continue living with her family even with the support of a provider agency. The Facility submitted documentation of the IDT's review of this individual's return to the Facility. It was not a critical review of the CLDP process. ▪ One had returned to CCSSLC after unsuccessfully living in a supported apartment, and a group home, and eventually becoming homeless, and then being incarcerated after allegedly breaking and entering. ▪ One had returned to another SSLC, after having charges filed against her. This was an individual that during a previous review as part of a post-move monitoring visit, the Monitor observed the individual being detained by police. She ultimately was psychiatrically hospitalized a number of times, and eventually, after allegedly aggressing towards staff, was arrested, and transferred to one of the SSLCs supporting a forensic population. o Another individual had two Emergency Room visits related to chest pain and a possible heart attack, and a hospitalization eventually for open-heart surgery. o The fifth individual had three different incidents, including: 1) an ER visit due to self-injurious behavior; 2) an ER visit for a sprained ankle; and 3) police contact due to making a false report. The Facility is strongly encouraged to conduct such reviews in the spirit of identifying ways in which improvements can be made to reduce preventable negative outcomes in the future. Good transition planning requires the commitment of the entire IDT, as well as those tasked with primary responsibility for developing the CLDPs. The entire team should be involved in critical, but constructive reviews of issues that individuals have experienced once they transition to the community. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred. Although progress continued to be made in this area, the Facility recognized the need to fully develop and implement quality assurance processes necessary to assess its	

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		implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability between all auditors responsibility for monitoring. 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 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.	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. Although the report was undated, the State provided it to the Monitors and DOJ on February 26, 2013, six months after the data collection period ended. The following summarizes some positive aspects of the report: ▪ The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. ▪ There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. ▪ DADS included a list of 12 initiatives it was continuing to support. Five were related to the IDT/ISP process and ongoing changes to this process; three were related to working with local authorities and local agencies, including a pilot project with the Austin SSLC; one was related to the Community Living Specialist positions that DADS created using Money Follows the Person funds; one was related to ongoing implementation of existing Home and Community-Based Medicaid Waivers; and two were related to reviewing negative outcomes for individuals that transitioned to the community (i.e., conducting mortality reviews, and reviewing other negative outcomes such as arrests, psychiatric hospitalizations, etc.). In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). ▪ The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: ▪ Section T.1.b.1 of the Settlement Agreement requires that within two years each individual's team "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." It is important to note that the State's definition of obstacles was not consistent with this definition from the Settlement Agreement (i.e., on page	Noncompliance

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		2, the report read: "Obstacles are defined as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting.") At the time the data for this report was available, the Settlement Agreement had been in the implementation phase for three years, but significant problems continued to be noted with the data available. For example: o As the report indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. For example, for CCSSLC, the total number of obstacles for referral was 20. Given that at the time, according to the Facility-specific report, the census was 258, and in FY 2012, approximately 17 individuals were referred for transition to the community, many data were missing. o This might have been complicated by the fact that Table 4 in each of the Facility-specific reports was labeled: "Residents not recommended for movement that prefer to reside in the community from the [Facility Name] State Supported Living Center, 2012." Based on some of the narratives and data provided, it appeared Facilities had interpreted this differently. In some instances, it appeared Facilities had provided data for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community (e.g., Abilene SSLC). However, in other instances, it appeared this data was for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it (e.g., Lubbock SSLC). Both sets of information were important, and the reports certainly should have included the data on obstacles for all individuals the Facilities supported. o As the State noted in the report: "Data collected from each respective facility varied, from very detailed obstacle identification/collection to little to no obstacles identified. Within each facility report, a plan for future obstacle identification and collection is provided." Although it was positive that the State recognized the need for improvements with data, at this juncture of the implementation of the Settlement Agreement, it is concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for CCSSLC, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new	

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		data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. o As the Monitors discussed with the parties, at this juncture, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. ▪ The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement requires. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. For example, for CCSSLC, no analysis was provided of the data. Beyond the actions related to improving the data collection related to obstacles, the only actions the Facility proposed to take were to continue the educational opportunities available to individuals and their guardians (e.g., provider fair, CLOIP information, CLOIP tours), and then the following vague activities: 1) "The IDTs will explore the availability of community specialized medical supports in those counties where a lack of these supports has been identified as the obstacle for residents moving to a service delivery setting of his/her choice;" and 2) "The APC and QDDP coordinator will work with the local authority regarding the annual CLOIP." The Facility offered no recommendations to DADS. ▪ The lack of complete data as well as lack of "comprehensive assessment" of the data from the Facilities limited the State's ability to comply with the requirement that: "Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature." Moreover, it was unclear how the State intended to comply with this requirement without conducting and including in the report an analysis on a systemic level of the data the Facilities provided. As noted above, DADS included a list of initiatives it was continuing to support. However, even with the clear problems with full data collection, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred for transition due to "Behavioral	

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		health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals had encountered the following obstacle to transition: "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred to the community due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals had encountered the following obstacle to transition: "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" ▪ In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
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	In response to a document request, the Facility submitted a Community Placement Report. For the time period between 6/1/12 and 1/31/13, the report listed: ▪ Current Referrals: Seventeen individuals were included on this list, but three of these individuals had transitioned to the community since the report was issued. Of concern, based on the Monitoring Team's review of a sample of ISPs, Individual #59's team had referred him for transition within this time period, but he was not on the list. He also was not on the list of rescinded referrals. Although this seemed an isolated incident, to maintain a substantial compliance rating, this list needs to be accurate. ▪ Community Placements: Seven individuals were included on this list. As noted above, three additional people had transitioned in the weeks prior to the review. One individual on the list also had returned to the Facility. ▪ Rescinded Referrals: One individual was included on this list. The reason was IDT decision: Medical and Other Reason. The Monitoring Panel had 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	Substantial Compliance

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	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.	community. For meetings occurring between 6/1/12 and 1/31/13, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included seven individuals. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included eight individuals. For two individuals, citizenship issues were identified as the reason. For two other individuals, the reason listed was "exploring community options. For one individual, "legal issues" was the reason listed. For two individuals, behavior/psychiatric issues were listed. For one individual, "other" was the reason, with no further explanation. The Monitoring Panel asked that a final category be added that included 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. The Facility provided a separate list of three individuals that fell into this category (i.e., TX-CC-XVI.4). However, as noted above with regard to Section 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. This was not yet happening consistently. Therefore, it was unlikely that this data was yet reliable. While on site, the Monitoring Team asked for clarification of this list. The Facility then produced the list of seven individuals identified above in the section of the Community Placement Report entitled: "Individual Prefers Community, Not Referred – Other Reasons." This was a subset of the individuals that should have been identified for this final category. This list should have included all individuals for whom the team recommended transition, but the reason a referral was not made was LAR choice.	
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for nine individuals (i.e., Individual #231, Individual #69, Individual #208, Individual #62, Individual #71, Individual #341, Individual #63, Individual #213, and Individual #140). This sample represented all (100%) of the individuals for whom the CCSSLC Post-Move Monitor needed to complete reviews during the previous six months. For the nine individuals, 20 reviews should have been completed during this time period. Of the 20 required visits, all (100%) had been documented as having been completed on time. In addition, monitoring visits were conducted at the various sites at which supports were	Noncompliance

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	supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	provided. As applicable, the Post-Move Monitor appeared to have consistently visited individuals at their residential as well as their day/vocational sites. Content of Checklists: CCSSLC continued to use the revised format that the State Office had developed for post-move monitoring activities, which had been modified in November 2012. Each of the items on the checklists reviewed had been addressed. Additional information had been added regarding the interviews conducted, the documents reviewed, and the observations made. It was positive that the Post-Move Monitor thoroughly described the methodology used to confirm the existence of necessary protections, supports, and services. The checklists reviewed generally were completed thoroughly. In other words, all pre-move and post-move supports were reviewed, and the evidence that was used to support the findings was documented. At times, issues were noted that required follow-up. Some of these involved supports that had not been fully provided and/or issues that had arisen since the transition. Generally, based on the evidence provided, it appeared that the Post-Move Monitor had correctly rated the pre-move and post-move supports as being present or not. For one individual (i.e., Individual #213), however, issues were noted. This individual had complex medical needs, and likely the issues noted reflected the fact that the Post-Move Monitor did not have the requisite clinical expertise, so did not understand the import of the issues. The more specific issues noted are detailed below with regard to Section T.2.b. Use of Facility's Best Efforts to Ensure Supports Are Implemented The primary reasons for conducting post-move monitoring are to identify if the protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. The following summarizes the findings of the review of post-move monitoring documentation: ▪ Of the nine individuals reviewed, seven of them (78%) had needs identified for which follow-up was necessary to ensure supports were implemented (i.e., Individual #69, Individual #208, Individual #140, Individual #71, Individual #213, Individual #345, and Individual #63). ▪ Of the seven individuals for whom follow-up was indicated, documentation was present to show that for one individual (14%), sufficient follow-up had occurred (i.e., Individual #71, for whom minimal issues were noted, and the Post-Move Monitor requested that the provider agency make corrections) to address the issues identified. In some instances, it appeared that the Post-Move Monitor had taken a number of steps to follow-up. However, despite the Monitoring Team's	

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		request for post-move monitoring documentation: "including additional documentation, if any, that reflects follow-up activity taken by the PMM, IDT, or the Facility in response to issues identified in the post-move monitoring checklists," it was not clear that teams of the Facility had taken timely action. At times, even when the PMM identified the need for the individual's CCSSLC IDT to review and make recommendations about specific issues identified during the post-move monitoring visits, this was not consistently done or documented. Some examples included: o For Individual #69, one of the post-move supports specifically stated: "The IDT has agreed to have [Individual] remain with the same medication and any changes in medication should be noted to the Post Move Monitor so the IDT can be mad of the medication change and assess [Individual's] health." During the 90-day visit, the Post-Move Monitor noted a change in his psychotropic medication after what appeared to be one behavioral incident at the day program, and some reported sleeplessness. No documentation was submitted to show that the team responded or did what it said it would do in the post-move support. o For Individual #140, the provider failed to identify counseling services, and was late in identifying a BCBA. In the meantime, Individual #140's behaviors were problematic. While the Post-Move Monitor continued to encourage the provider to follow through on the supports included in the CLDP, she also recommended the IDT at CCSSLC review the issues. No documentation was submitted to show this occurred. In addition, it did not appear that other resources were solicited, such as help from the Local Authority in identifying appropriate services, particularly when the provider indicated they were having trouble finding counselors that accepted Medicaid. o For Individual #63, at the 45-day and 90-day, a number of post-move supports had not been put in place in a timely manner. For example, at the 45-day review, a psychologist had not seen him nor had a nephrologist seen him, and at the 90-day review, a dietician had not seen him. This was an individual with significant medical issues and a history of behavioral issues that had placed him and others at risk. While the Post-Move Monitor continued to encourage the provider to follow through on the supports included in the CLDP, she also recommended the IDT at CCSSLC review the issues. Although documentation of a team meeting was found after the seven-day review, no evidence was provided that the team acted to review the 45-day or 90-day information, and/or to make recommendations to ensure Individual #63 was receiving the supports he needed. In addition, the	

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		provider indicated it was difficult to find a dietician in the area, but no efforts were made to involve other entities, such as the Local Authority in identifying appropriate services. o For Individual #345, at the 45-day review, the provider had not addressed two fairly significant post-move supports, including taking blood pressure checks, and identifying a BCBA or psychologist to work with him. The action plan simply stated that the provider would work on these items. It was unclear why a blood pressure cuff that should have been available at the seven-day monitoring could not easily be obtained. The reason for a psychologist not being in place was not stated in the report. However, for this individual, this was a key support, and further intervention by the team or Facility was necessary to ensure this deficiency was corrected as soon as possible. o The seven-day monitoring report for Individual #213 indicated that the team was to beet to "discuss concerns and issues that both CCSSLC and [provider] staff have regarding [Individual]." If the meeting occurred, the Facility did not provide the documentation to the Monitoring Team. The Facility generally had maintained the progress it had made with regard to post-move monitoring. However, as individuals with more complex medical needs move to the community, additional clinical input will be needed in the post-move monitoring process to ensure clinical supports are properly assessed. In addition, follow-up to the monitoring visits remained the biggest challenge for the Facility. This will require the efforts of individuals' IDTs, as well as the Admissions and Placement Office. The Facility remained out of compliance with this provision.	
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	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #213, including to his day program and home. The Monitoring Team appreciates the Post-Move Monitor finalizing the report from the visit, because this provided the opportunity to compare the observations of the visit with the written report. As has been noted in the past, the Post-Move Monitor systematically reviewed the supports included in Individual #213's CLDP. She asked many good questions, conducted observations, and reviewed relevant documentation. During the course of the review, the Post-Move Monitor identified some issues, including some related to supports included in the pre- and post-move list on the CLDP, as well as others, such as a lack of adequate food in the home. The Post-Move Monitor worked professionally with the provider staff to discuss these issues and potential solutions. However, in reviewing the resulting report, the Post-Move Monitor had not consistently correctly rated the pre-	Noncompliance

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	date.	move and post-move supports as being present or not. Individual #213 had complex medical needs, and likely the issues with the accuracy of the monitoring reflected the fact that the Post-Move Monitor did not have the requisite clinical expertise, so did not understand the import of the issues. More specifically, for Individual #213, "yes" ratings were given to the following supports for which the evidence did not show the provider had fully implemented the supports: tracking every shift of changes to his suprapubic dressing and cleaning of the site, three supports that related to staff documenting the individual's input (as well as output), a nurse checking the former decubitus site daily, checking his Depends Brief every two hours while awake and at 2 a.m., completion of an OT (as well as PT) assessment, and the individual's use of the prone wheeler. All of these supports should have been rated as "no." In some cases, the provider had modified a support or the individual was refusing to participate in a support, but this was not taken back to team to determine if the modifications were appropriate or if an alternative or specific strategies would have helped with the individual's compliance. Given that these supports directly related to the health of the individual, it was concerning that the community provider agency had agreed to provide the supports as written, but was making changes without checking with the CCSSLC IDT. For the past review, the Facility was found in substantial compliance with this provision. However, for this review, a finding of noncompliance has been made. As has been discussed, maintaining substantial compliance was dependent on the post-move monitoring keeping pace the expanded responsibilities as more supports are included in CLDPs, particularly for individuals with complex medical needs.	
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.	The parties had agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC. Since the last review, two individuals had transferred another SSLCs (i.e., Individual #178 and Individual #246). Based on a review of the discharge summaries completed for Individual #178 and Individual #246, it contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. However, in some cases, this summary did not "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plan did not appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: Based on the information provided, in two out of two records reviewed (100%), good cause was identified in the discharge summaries (i.e., team's agreement, including his guardians, that movement would offer additional opportunities for family involvement). ▪ The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, for two out of two individuals (100%), reasonable time was given to prepare. ▪ At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: Although the final summary included each of these components, for none of the two individuals (0%) was the information adequate. Some improvement was seen in this regard. For example, more relevant information was provided about some of the physical and nutritional management supports, as well as psychiatric information. However, concerns included: o Incomplete historical and current status information was provided (e.g., little historical information was provided regarding the individual's stay at the Facility). o Generally, little information was provided about the supports the	Noncompliance

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		individual was receiving, and little analysis was provided regarding what supports had assisted the individual versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. For example, both individuals were described as having significant behavioral issues. However, the behavioral summaries were very general, and did not provide the receiving facility specific information about the individuals' current status or which interventions were most effective. In addition, for Individual #246, there was conflicting information in the psychiatric and psychological summaries (i.e., self-injurious behavior). o Although more information was provided about psychiatric status then seen previously, the summaries provided inadequate information about attempts at CCSSLC to modify his medications, review his diagnoses, etc., and/or determine if the current psychiatric treatment was effective. ▪ With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: For none of the two individuals (0%), CCSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. Although for Individual #248, a copy of the sign-in sheet was provided for the meeting, which included the guardian and individual, it was unclear if a representative(s) from the receiving facility participated. ▪ The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for none of the two individuals (0%) adequately described the key supports that the individual would need in his new setting. This section of the support simply stated: "A complete re-assessment of all needed supports/services will be conducted by the [SSLC] upon his arrival." The information included in the other sections of the summary was largely assessment information or narratives regarding general status. Although some supports he was receiving were included as recommendations for Individual #245, a specific and comprehensive list was not included anywhere in the document. The Facility was not in compliance with this provision. This was due to the fact that it did not meet the CMS requirements for transition/discharge planning.	

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

1. As has been recommended in previous reports, 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. (Section T.1.b)
2. 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. Given that the current categories on the ISP format were not capturing the common categories of LAR and individual concerns, the list should be expanded. (Section T.1.b.1)
3. 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 ISP to document that individuals and their families are making informed decisions with regard to an individual's living options. (Section T.1.b.1)
4. With regard to education opportunities:
    a. For the CLOIP process, outcomes/measures should be determined and/or data collected regarding the number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options, and the number of individuals and families/LARs who refuse to participate in the CLOIP process. Collection and review of such data should be completed to allow the State to evaluate the effects of the process and make changes to future CLOIP activities.
    b. With regard to community tours, data should be analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individual's specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed.
    c. The Facility should develop a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals.
    d. The Facility should provide opportunities for individuals to visit friends who live in community;
    e. If the analysis of aggregate data showed that families and guardians had similar concerns, then using mechanisms to provide information on specific topics should be used. For example, including articles in newsletters or offering specific educational seminars might be useful.
    f. The Facility should provide education at: house meetings for the individuals.
    g. The Facility should add creative and individualized educational activities to meet the needs of various individuals and families/guardians, including action plans in individuals' ISPs designed to meet their specific needs. (Section T.1.b.2)
5. The Facility should analyze the reasons teams, independent of the LAR and individual, are not making recommendations regarding individuals' transition to the community that are justified by the recommendations in team members' assessments and/or the discussion documented in the ISPs, and that teams frequently not documenting reconciliation of differences in opinion noted in the recommendations in assessments. Based on the results of this analysis, the Facility should develop and implement a corrective action plan. (Section T.1.a and T.1.b.3)
6. Given that from a normalization perspective, when people move, often one of the hardest aspects is leaving friends behind, and typically plans would be made to help stay in touch with important colleagues or friends, as appropriate, it would be important to include such activities in individuals' transition plans. (Section T.1.c.1)
7. Pre-move and post-move supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility and community provider staff in the transition and discharge process should be defined better. This should include, but not be limited to defining:
        i. Which community provider staff need to complete which training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or for each component of training, what level of mastery of the information is required (e.g., demonstration of competence);

ii. 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 PBSP, PNMP, etc. For some individuals, specific components of their ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an pre-move support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual;
iii. Collaboration between the Facility clinicians currently working with the individual and the community clinicians who will assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.);
iv. Coordination between current and future residential or day/vocational staff;
v. CCSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Behavioral Services Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment); and
vi. The role CCSSLC staff or community provider staff might play in assisting the individual to make the transition;

b. Due to the current inadequacies of the ISPs, teams should start at the beginning, and describe the full array of supports the individual needs and prefers. Once these are listed, the CLDPs should identify how the necessary supports will be provided in the community, by whom, when, with what frequency, and for how long. This can be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they do for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built;
c. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians;
d. Clinical supports that CCSSLC is providing should be included in the CLDPs, or adequate justification for not identifying a functionally equivalent support should be documented in the CLDP;
e. For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible;
f. In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community;
g. Teams should factor in modifications that need to be made to current programs or plans, and write such modifications into the pre-move or post-move supports;
h. As appropriate, teams should identify as post-move supports the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications might need to be made to the methodology for providing these supports, with the end result being the individual's need for the support being met;
i. For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff;
j. As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
k. Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.);

l. Recommendations in assessments should be addressed specifically in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.), and justification provided for any recommendation not included as an pre-move or post-move support;
m. As recommended previously, CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community;
n. Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component;
o. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle; and
p. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

8. In addition to addressing recommendations related to assessments in other sections of this report to improve the overall quality of assessments used in developing CLDPs, modifications should be made to assessments to:
   a. Provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility;
   b. Assist teams in developing a comprehensive list of protections, supports, and services in a community setting. Assessments should describe or recommend the protections, treatments, and supports that an individual requires (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), as well as the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.); and
   c. Identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. (Section T.1.d)
9. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to 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.). This should be comprehensive, and not just include general medical information, but also specialists' involvement with individuals. This would facilitate the transition of this information to community medical care providers. (Section T.1.d)
10. The State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., are transferred to a mental health hospital after transitioning to the community), whose community transitions are in jeopardy, or who experience other serious negative outcomes. (Section T.1.f)
11. With regard to monitoring activities related to the Facility's performance with this section of the Settlement Agreement, the Facility should:
    a. Modify, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors;
    b. Ensure the reviews accurately evaluate quality as well as the presence or absence of items;
    c. Establish inter-rater reliability; and
    d. 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 T.1.f)

12. With regard to the obstacles report:
    a. The format the State provides Facilities for their Facility-specific obstacle reports should include data for the list of obstacles to referral for all individuals at the Facility, as well as the subgroup of individuals who have expressed an interest in transition, but their guardians are reluctant to consider it.
    b. The State should define the process Facilities use to collect data on obstacles to transition.
    c. The Facility should expand the analysis of the data included in its Facility-specific report, include specific action plans to address the findings from the analysis, and whenever issues identified are outside of the scope of the Facility to correct, the Facility should include recommendations for DADS' intervention.
    d. The State should conduct and include in the report an analysis on a systemic level of the data the Facilities provide, and provide a description of the specific steps, if any, the State had or planned to take "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities…"
    e. In the obstacles report, the State should include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). (Section T.1.g)
13. As individuals with more complex medical needs move to the community, the Post-Move Monitor should have access to additional clinical input to ensure clinical supports are properly assessed. Such input could be provided through clinical staff on the individuals' teams, or clinical staff in the QA Department. It also could take different forms, including on a consultative basis (e.g., defining documentation needed and reviewing it once the Post-Move Monitor returns to the Facility), or joint monitoring. (Sections T.2.a and T.2.b)
14. CCSSLC should review the transition/discharge summary process that it is using for individuals who undergo "alternate discharges" to ensure that the requirements set forth by CMS are met, including a process that:
    a. "[A]ccurately describes the individual, including his/her strengths, needs, required services, social relationships and preferences" [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]; and
    b. Provides a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement" [42 CFR §483.440(b)(5)(ii), and W205]. (Section T.4)

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section U; o CCSSLC policies, including: ▪ Corpus Christi State Supported Living Center – Statewide Policy and Procedures, Policy #057 – Self-Advocacy, dated 5/30/12; ▪ Policy #UU.9 – Rights and Protection Complaint Resolution, implementation date 3/9/12; ▪ Policy UU.11 – Review of Restrictive Behavior Support Plans and Crisis Intervention Plans by the Human Rights Committee (HRC), implementation date 5/1/12; and ▪ Policy UU.12 – Review of Psychotropic Medications, Pre-Sedation and Sedations for Medical Appointments by the HRC, implementation date 5/1/12; o In response to request for: "Any instruments or processes used to determine functional capacity, and any instruments or processes used to prioritize the needs of the individuals," the response: "No Evidence For File;" o In response to the request for: "Curricula for training on the instruments or processes referenced above," the response: "No Evidence For File;" o CCSSLC Guardianship Priority List, dated 10/31/12 and 2/1/13; o List of individuals for whom a Legally Authorized Representative (LAR) or Advocate was obtained, May to October 2012; o Annual HSC Provider Fair flyer; o Section U – Consent Monthly Reports from the QA Department, for the months of September 2012 through February 2013; o Membership and Affiliation of the CCSSLC Guardianship Committee; o Guardianship Committee Minutes, dated 4/4/13; o Self-Assessment for Section U; o Provision Action Information for Section U; o Action Plans for Section U; 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 Karen Forrester, Human Rights Officer (HRO); and o Karen Ryder, Program Compliance Monitor.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U, dated 3/18/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section U, in conducting its self-assessment: ▪ The Facility was using the Settlement Agreement Cross Referenced with ICF-MR Standards Section U – Consent monitoring/audit tool: o Based on interview with Facility staff, work had been done to refine the original Section U monitoring tool, including the addition of instructions. According to the PCM and HRO, they had met to discuss inter-rater reliability results, and since the Monitoring Team's last review had made changes to the tool twice. Based on the Monitoring Team's review of the instructions included on the most recent version of the tool, dated 2/7/13, they were a good attempt at identifying the documentation that auditors would need to review. However, they were not complete instructions that would lend to various auditors' consistent implementation of the tool. For example, although the documents that auditors would review were now more clearly identified, it remained unclear what standards the auditors would use when reviewing these documents to determine compliance with the indicators. Standards were an important but missing component, because the audits needed to measure not just the presence, but the quality of teams' assessments, inclusion of guardianship information in individuals' ISPs, and teams' efforts to obtain guardians for individuals. It should be noted that the PCM and HRO appeared to have discussed the standards they were using for a number of the indicators, but had not included them in the instructions they had developed. In addition, as the most recent draft of the monitoring tool indicated, the State had not yet decided upon a process or assessment to estimate individuals' functional capacity for decision-making. Once such a process or assessment is identified, the monitoring tool for Section U likely will need to be revised. o This monitoring tool included indicators to allow the Facility to determine compliance with the Settlement Agreement. However, consideration should be given to how the indicators on the current audit tool were assisting the Facility to identify specific areas in which effort was needed. In reviewing the QA Monthly Report, the Facility was collapsing the indicators for questions #1 through #3 into overall scores. If the current indictors do not provide discrete information that is helpful to the Facility's analysis, then the Facility should consider revising the indicators. If the decision is made to continue with the current indicators, data should not be collapsed into "overall" scores, which provide little if any meaning to assist in the analysis process. o The following staff/positions were responsible for completing the audit tools: the HRO and the Program Compliance Monitor.

	o Although the Facility did not have a process to determine if the staff responsible for conducting the audits were competent in the use of the tools, the two staff identified had experience that would potentially provided them with the programmatic knowledge necessary to audit this area. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. o The Self-Assessment identified the sample(s) sizes. Although an attempt was made to include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size), it did not appear this had been done correctly for Section U.1. A percentage was provided, but it was the percentage of records reviewed, and did not give a comparison to the overall population. ▪ The Facility Self-Assessment identified some appropriate methodologies, such as record and policy review. ▪ In its current Self-Assessment, the Facility used other relevant data sources. For example, the Self-Assessment provided numbers and percentages of individuals with guardians as well as numbers of individuals for whom guardians had been appointed. ▪ The Facility rated itself as being in compliance with none of the subsections of Section U. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment did not provide an analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Corrective Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Although the QA Monthly reports provided some limited analysis and description of plans to address some of the issues, no reference was made to this information in the Facility Self-Assessment. Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process likely will need to be modified. For example, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports.
	Summary of Monitor's Assessment: At the time of the review, the State Office policy on consent had not been issued. The Facility did not yet have an assessment or process to determine an individual's "functional capacity to render a decision regarding the individual's health or welfare." Facility staff indicated State Office had asked them to put a project to identify such a process on hold. As has been stated in previous reports, until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. As noted in the last report, teams at the Facility had completed Individual Support Plan Addenda to identify individuals' priority level for obtaining a guardian, but the Monitoring Team noted a number of problems with the process. Based on this process, CCSSLC generated a prioritized list of individuals needing

	guardians, and had continued to update it on a quarterly basis. The most recent list the Facility provided was dated 2/1/13. It included a total of 248 names. Of these, 162 individuals were identified as adults with no guardians, but needing guardians. This group included 42 individuals with a Level 1 priority need for guardianship (the highest level), 99 with Level II priority need, and 21 with Level III priority need. Another 86 individuals were identified as adults with guardians or with no priority level for guardianship. Since the last review, no guardians had been identified for individuals who needed them. As noted in past reports, CCSSLC had made efforts to identify potential guardianship resources. However, at the time of the review, no viable resources had been identified, but Facility staff were still making efforts to identify family members or others with whom individuals had relationships to petition for guardianship. It will be essential that adequate resources be identified to address this need. Since the last review, the Facility had developed a Guardianship Committee, which was a positive step forward. One staff person from the Local Authority and one individual that resided at CCSSLC were Committee members along with a number of staff from CCSSLC. Efforts continued to identify additional community members to join the Committee. The Committee was meeting regularly and had begun to further prioritize the list of individuals potentially requiring guardians. The Committee had identified a list of 10 individuals that would most benefit from the appointment of a guardian. However, the process the Committee used included almost identical criteria to those the teams used, and appeared to be a subjective process using the Committee members' knowledge of individuals, as opposed to a more objective process that took into consideration individuals' specific needs and risks.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for	Since the Monitoring Team's last review, no new DADS or CCSSLC local policies had been developed in relationship to consent or guardianship. For the past several reports, it was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. However, at the time of the review, such a policy had not been issued and limited progress had been made with regard to consent and guardianship. The State is encouraged to finalize a consent policy, because it should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. Based on interview with staff, the Facility did not yet have an assessment or process to determine an individual's "functional capacity to render a decision regarding the individual's health or welfare." Facility staff reported they had developed a corrective action plan to identify/develop such a tool. However, they indicated State Office had asked them to put this project on hold. As has been stated in previous reports, until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires.	Noncompliance

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	decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	However, as reported after the Monitoring Team's review in July 2012, after the State Office issued its policy on guardianship, CCSSLC teams met to review all individuals the Facility supported and determine their guardianship priority level. A workgroup had developed an ISP addendum template that teams used to structure and document their discussions. The template essentially repeated in question format the criteria included in the Settlement Agreement and State policy in relation to factors that might prioritize one individual's need for a guardian over another individual's need. As noted in the Monitoring Team's previous report, based on review of documentation provided at that time, a number of problems were noted with regard to the implementation of the process: ▪ Based on the few completed ISPAs the Facility provided for the July 2012 review, it did not appear that the full team, including the individual, was involved in the decision-making review process. ▪ A missing component from this process was the adequate screening and/or assessment of individuals "functional capacity to render a decision regarding the individual's health or welfare." The first factor the team was to consider if an individual did not have a guardian read: "Does the person have a limited ability to express their own wishes or make determinations regarding their own health and welfare?" However, no tool was provided to assist teams in making this determination, and limited criteria were included on the form (i.e., "consider IDD level of moderate/severe or profound, moderate to severe communication status"). Without some further guidance, teams likely will use inconsistent criteria to make their decisions. ▪ In addition, because this initial factor (i.e., an individual's "ability to express their own wishes or make determinations regarding their own health and welfare") was weighted the same as the other three factors discussed below, it appeared that an individual might have no ability to communicate his/her wishes and no ability to make a determination about his/her health or welfare, but if none of the other factors were present, he/she would not be placed on the prioritized list for guardianship. ▪ The narratives included in the ISPAs addressing each of the four questions used to assist in prioritizing an individual's need for a guardian varied considerably in detail and quality. At the time of the Monitoring Team's most recent review, the Facility continued to base its prioritized list on the information gained through this process. Staff reported they updated the list approximately once a quarter to remove individuals that had died or transitioned to the community, as well as to add individuals admitted to the Facility. The only concern included in the Monitoring Team's previous report in relation to this screening process that the Facility had addressed related to individuals that had	

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		advocates through the Protection and Advocacy agency. During the July 2012 review, based on interview with staff and documentation review, it was noted that if an individual had an advocate through the Protection and Advocacy agency, they were not placed on the priority list for guardianship, even if they met the other criteria. Given that the Protection and Advocacy agency has no authority to make decisions on an individual's behalf, it was unclear why the Facility had made this distinction. Based on interview with staff during the most recent review in April 2013, this had been corrected, and as appropriate and based on the other criteria, individuals with Protection and Advocacy agency advocates were assigned a priority status. Based on this process, CCSSLC generated a prioritized list. The most recent one the Facility provided was dated 2/1/13. It included a total of 248 names. Of these, 162 individuals were identified as adults with no guardians, but needing guardians. This group included 42 with a Level 1 priority need for guardianship (the highest level), 99 with Level II priority need, and 21 with Level III priority need. Another 86 individuals were identified as adults with guardians or with no priority level for guardianship. As noted in previous reports, 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 he/she is able to make informed decisions as well as those areas in which he/she 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. The Human Rights Officer was an advisor to the Self-Advocacy Group. Some of their activities related to expanding individuals' knowledge of their rights, as well as consent-related issues. For example, some topics included discussions of pros and cons of certain decisions, such as decisions related to diet restrictions, the roles and responsibilities of the Human Rights Committee, voting, etc. Such efforts to provide education should assist some individuals to expand their decision-making capacity. As discussed, it will be important to expand these efforts, and for teams to individualize them. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-	

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		friendly manner, etc.). The Facility remained out of compliance with this component of the Settlement Agreement. The Facility had a prioritized list, but an adequate standardized process for determining individuals' functional capacity to render informed decisions still was not being used. In addition, although teams were becoming more involved in the process, including the identification of an individual's priority level for guardianship, sufficient criteria were not in place to standardize the process across teams. Once the State Office policy on consent 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 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.	Based on interviews with Facility staff and review of documentation, since the last review, no guardians had been identified for individuals who needed them. As noted in the Monitoring Team's previous reports, the Human Rights Officer had engaged in some efforts to identify potential guardianship resources. For example: ▪ Since the last review, after contacting a number of SSLCs, the HRO, with input from State Office, selected one SSLC to visit. During the visit, the HRO observed the other Facility's Guardianship Committee meeting. ▪ The HRO had scheduled a time to meet with the clerk of the local court with responsibility for guardianship proceedings to discuss resources available, particularly legal resources that interested parties could use to pursue guardianship. ▪ Past efforts included contacting some private entities that might have resources. However, according to CCSSLC staff, there were no known guardianship resources available in the area. For example, Facility staff had not been able to identify any for-profit or nonprofit guardianship entities to which referrals could be made. ▪ In the Monitoring Team's previous report, it was noted that the Facility had sent letters to all of the individuals' primary correspondents and/or guardians. Depending on the individual's status, the letter inquired about their willingness to consider becoming guardian for someone else at the Facility requested updated documentation for lapsed guardianships, or included some information about the importance of guardianship, and inquired about the family member's interest in pursuing guardianship. These letters generated some limited contact with the HRO about guardianship. ▪ Since then, beginning in January 2013, four to six weeks prior to individuals' ISP meetings, a letter was being sent to individuals for whom teams believed guardianship was needed. In addition to a cover letter that described guardianship in general terms, two fact sheets were enclosed, including "How Can A Guardian Support Someone Living At Corpus Christi State Supported	Noncompliance

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		Living Center," and "Guardianship Process in Texas." Based on interview with staff, these documents had been obtained from other facilities and customized to meet CCSSLC's needs. Staff also reported that some inquiries had been made as a result of the letters being sent. Staff were in the process of translating it into a Spanish version to assist some families in better understanding the guardianship process. ▪ The Facility had included in the cover letter information about the fact that individuals' funds could be used to cover the costs of guardianship. In discussions with staff, the "applied income" option that the Monitoring Team had referenced in its last report had been further investigated as an option. ▪ The HRO continued to attend State Office sponsored workgroups and training sessions, which included discussion of guardianship and consent issues. Such meetings had occurred in September 2012, and December 2012. ▪ In December 2013, the Human Rights Officer presented at a Family Association Meeting. ▪ In October 2012, the Self-Advocacy Group and Human Rights Officer had a booth at the Provider Fair. Guardianship and consent information was provided in these venues. ▪ As noted in the Monitoring Team's previous report, the Facility had begun to implement an advocacy program. This involved the recruitment of volunteers to serve as individuals' advocates. Since the time the program had been operational, advocates had been identified for four individuals, and another two potential matches were being considered. This potentially provided a resource to assist individuals in decision-making that was less restrictive than guardianship. The Facility should be commended for its efforts in this regard. All of these volunteer advocates were staff who had been determined to be conflict-free in advocating on behalf of the individual (i.e., not working directly with them, or supervising their supports). The HRO planned to provide training on advocacy opportunities at one of the required annual refresher training sessions. This was a creative idea, and as the Monitoring Team suggested might assist in increasing volunteer referrals for advocates and/or guardians from staff's friends or external colleagues. Since the last review, CCSSLC had implemented the portion of the State Office Guardianship policy that required development of a Guardianship Committee. As noted above, after reaching out to obtain information about what other Facilities were doing, the HRO had visited another SSLC with a functioning Guardianship Committee. Using this Committee as a model, CCSSLC had recruited members and begun to meet. At the time of the review, the Committee consisted mostly of members of the CCSSLC staff.	

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		However, the HRO from one of the Local Authorities was a member, and an individual CCSSLC supported joined the group beginning with the meeting held during the Monitoring Team's onsite review. The HRO also had attempted to and had future plans to recruit additional community members, which would be important and could be helpful in identifying resources related to alternatives to guardianship, potential guardians, as well as funding to support individuals for whom the guardianship fees prohibit them from applying to become a guardian. On 12/4/12, the Committee had its first meeting. Training was provided to the members, including training on relevant policies, as well as guardianship, legally adequate consent, rights, and roles and responsibilities of the Committee. The Facility provided minutes for the 12/4/12 meeting, as well as meetings on 1/22/13, and 4/4/13. At the 1/22/13 meting, the Committee reviewed the individuals whose teams had identified them as being at highest need for a guardian, and prioritized the list further by identifying the 10 individuals that would benefit most from having a guardian. As noted above, the Monitoring Team continued to have concerns about the process teams were using. In addition, based on review of the minutes and interview with staff, it was not clear that an objective process was used to further select the top ten individuals. The list of criteria the group used was essentially the same as the list teams were using, and the process described was one in which Committee members shared their knowledge of the individuals in the highest priority category. It is recommended that the Guardianship Committee develop and implement a more objective process for prioritizing the list of individuals potentially requiring guardianship, including, for example, record review, consideration of risk ratings and rates of hospitalizations, etc., and documenting the information used in its decision-making. As noted above, the current list of individuals potentially requiring guardians included 162 names. Although, as also discussed above, given the lack of adequate assessments, it was not clear if this was an accurate number, it will be essential that adequate resources to address individuals' need for guardians be identified. 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). 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, it should define the potential roles of SSLC staff in the process.	

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		In summary, the Facility continued to make efforts to implement the State Office policy on guardianship, and encourage family members or others with whom individuals had relationships to consider pursuing guardianship. However, these efforts were not yet resulting in individuals whom teams believed needed guardians obtaining them. The Facility remained out of compliance with this provision.	

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

1. The State should finalize the State Office policy on 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. 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. (Section U.1)
2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation. (Section U.1)
3. Once the State policy is finalized, CCSSLC should develop and/or revise its policies related to consent to reflect the State policy. (Section U.1)
4. Once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility. (Section U.1)
5. Based on its monitoring activities, the Facility should identify areas in which teams require further guidance regarding their responses to the questions related to prioritizing an individual's need for a guardian. As appropriate, additional guidance should be developed and provided to teams with a goal of increasing consistency between teams. (Section U.1)
6. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)
7. The Guardianship Committee should develop and implement a more objective process for prioritizing the list of individuals potentially requiring guardianship, including, for example, record review, consideration of risk ratings and rates of hospitalizations, etc., and documenting the information used in its decision-making. (Section U.2)
8. 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 U.2)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policy V.3 – Security of Records and Using a Special Check-Out Binder in Each Active Record Area, implemented 11/29/12; o CCSSLC Filing and Retention Schedule; o List of Persons Responsible for Management of Records; o Description of Quality Assurance Procedures; o Section V Corrective Action Plan, undated; o Master Record Order and Guidelines: Historical Records; o Master Record Order and Guidelines: Inactive Records; o Active Record Order and Guideline; o Individual Notebook: Guidelines and Retention Schedule; o Master Table of Contents of Policy and Procedure; o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; o Samples of training materials and documentation of completion of training on recently approved policies; o For the last three months, trending reports for Section V reviewed at monthly QA meetings with Records Department staff; and o Presentation Book for Section V. ▪ **Interviews with**: o Kimberly Quarry, Unified Records Coordinator; and o Edesiri Onovughe, Medical Records Coordinator; o Dana VerHey, Program Compliance Monitor.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section V of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. In its Self-Assessment, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. A number of the indicators included in the Facility Self-Assessment for Section V had merit. As discussed with regard to Section V.3, the Facility was continuing to work on establishing inter-rater reliability between the Records Department and QA Department staff responsible for auditing. In addition, some basic data descriptions were now available, and the Facility recognized that the next step was further in-depth analysis of this information. Overall, the Facility had demonstrated that it was beginning to incorporate some of the data it had collected into its self-assessment process. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed.

	Summary of Monitor's Assessment: CCSSLC continued to maintain Active Records as well as Individual Notebooks. Since the last review, all individuals' historical files had been converted to the Master Record format State Office issued. A significant amount of historical information had been sent to an outside vendor to maintain. The Facility continued to use an Active Records Documentation Log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed. As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. The Facility had developed a system to track draft policies through to finalization. At that time, a process also recently had begun to track the training of staff on new or revised policies. Based on interview, the Facility was still working on a method to accurately track who had been trained, and which staff still required training. CCSSLC was conducting the required five records each month. A Program Compliance Monitor from the QA Department also involved in the process. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends remained in the beginning stages of development.

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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.	At the time of the Monitoring Team's review, two file clerks were assigned to each unit. The file clerks assisted with the maintenance of the records. As indicated in the Monitoring Team's previous reports, all individuals' Active Records had been converted to the new Table of Contents. Since that time, the State Office had issued revisions to the Table of Contents, and changes had been made in the active records across campus. The Records Department was in the planning stages to implement an additional revision in May 2013. File Clerks continued to have responsibility for maintaining the Active Records, for the most part. However, some exceptions had been made to this. Some of these distinctions were described in the previous report. 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 file clerks removed data related to individuals skill plans and PBSPs on a monthly basis, and filed it in the active records. A Corrective Action Plan had been developed and implemented with regard to the conversion of individuals' historical files to the Master Record format. Since the last review, the Medical Records Coordinator had completed the conversion of records. In	Noncompliance

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		addition, information that could be stored offsite had been prepared and sent to a secure warehouse from which retrieval was readily available should there be a need for the records. Similar to the previous review, from a limited review of records while on site, it was noted that very few documents were missing from the records. In the past, issues had been noted with regard to Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans, but during this review, they were generally found in the records. As noted in the last report, one of the mechanisms that seemed to have had a positive effect was the implementation of the Active Records Document log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed. This was an electronic system, which allowed functions such as auto-populating fields, and linking references to documents to their electronic version. It also allowed tracking and trending to be completed more easily. As noted in the Monitoring Team's past three reports, the Facility had an Active Record Check out procedure. This procedure went into effect any time an individual's active record needed to leave the unit, for example, for medical appointments or an ISP meeting. This policy addressed an essential component of maintaining control over the security of the records. As the Facility recognized, the next steps towards compliance with this provision was using the information from its audits to identify and address issues related to the quality of the records. The Facility continued to make progress in this area. Since the last review, the Master Records conversion had been completed. In addition to ensuring that the records are maintained properly, it will be important for the Facility to use its monitoring results to identify any areas in which the records might not meet the requirements of Appendix D of the Settlement Agreement, and take action, as appropriate, to correct them. At the time of the review, the Facility remained out of compliance with this provision.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as	As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. As noted in the Monitoring Team's last two reports, the Facility had developed a system to track draft policies through to finalization. At that time, a process also recently had begun to track the training of staff on new or revised policies. Based on a review of a	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	sample of policies and the related training, the tracking process seemed to capture some of the essential elements, included who needed to be trained, who would provide the training, and the curriculum used. Based on interview, the Facility was still working on a method to accurately track who had been trained, and which staff still required training. Currently, discipline heads were responsible for much of this with some assistance from the Competency Training Department. However, further work was needed to refine the process. The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. However, it was not yet in compliance with this provision. In addition to continuing to develop and revise policies in concert with the issuance of State Office policies, the Facility also should continue to ensure that staff who require training on the policies complete the training adequate to facilitate the policies' implementation.	
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.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ The Unified Records Coordinators were conducting record reviews. ▪ Based on the documentation provided, it appeared that five reviews were being conducted each month. ▪ The Program Compliance Monitor from the QA Department was working with the Unified Records Coordinator to select the records for review, conduct a sample of reviews, as well as to assist with the compilation of data. They continued to work on establishing inter-rater reliability, and were meeting monthly. ▪ To conduct the audits, the monitors were completing the Active Record Order Guidelines Audit Tool, and then the information collected was used to complete the monitoring tool entitled "Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4." ▪ Issues identified through the monitoring process with regard to individual records were addressed with the specific File Clerks. Individualized training or technical assistance was provided. In addition, Audit Trackers were sent to disciplines heads requesting corrections, if other departments were involved. The discipline heads were responsible to document actions taken. Areas in which improvements should be made in order to achieve compliance, included: ▪ The Facility had taken some initial steps in the analysis process. Specifically, the PCM had completed summary reports in which the data was described in more detail. This information could be used to conduct an in-depth analysis to try to answer the question "why." The Facility recognized that this was the next step	Noncompliance

#	Provision	Assessment of Status	Compliance
		in the process. The Records Department staff had continued to meet with the Program Compliance Monitor to discuss monitoring results in any meaningful way. ▪ Efforts had begun to ensure that those conducting the audits had been properly trained, and that there was adequate inter-rater reliability. As noted in other sections of this report, it is essential that inter-rater reliability be established using a standardized process. In addition, accuracy of monitoring is essential. This will require the development of adequate instructions and clear criteria for rating items on the audit tools. Although some instructions had been included on a revised audit tool, these were limited, and would benefit from expansion. Although the Facility continued to complete some of the tasks that required with regard to this provision of the Settlement Agreement, CCSSLC had not fully analyzed the results of monitoring data. Some corrective action plans had been developed and implemented. However, more specific plans likely would be needed once more extensive analysis was completed. The Facility also was still in the process of finalizing instructions for monitoring tools, and establishing inter-rater reliability. The Facility remained out of compliance with this provision.	
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.	Recently, the Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. CCSSLC had not incorporated this structure into their internal monitoring. The following represent the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although CCSSLC was not yet self-assessing this, the Monitoring Team observed that: o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted in the Monitoring Team's previous reports, to address issues related to the timely filing of information needed to make decisions, CCSSLC had developed a process to track the submission and timely filing of information in the Active Record. The impact of this policy and the related efforts appeared to have been significant. This process appeared to have improved the accountability for the timely filing of documents in the records. However, as the Facility's monitoring activities showed, some issues continued to exist with the timely availability of documents in Active Records. The new system was helpful in identifying where problems had occurred, increasing accountability.	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. For example, the Monitoring Team regularly found that nursing staff were not adequately documenting ongoing assessments and/or the results of such assessments. o Work continued with various departments, such as skill acquisition, psychology, and nursing to improve the data that staff maintained. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** The Unified Records Coordinators were asking a sample of team members to complete the questions that State Office had sent related to Section V.4. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** The Facility had not yet developed a process for incorporating information regarding the use of records during relevant meetings into the monitoring or database for Section V.4. As discussed in previous reports, this should include observations of a variety of meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.). The Unified Records Coordinators might not do this, but such indicators might be distributed in other monitoring tools, and the data fed back to the Records Department. Based on the Monitoring Team's observations and record reviews: o As discussed with regard to Section F and Section I of the Settlement Agreement, although improvement was seen, ISPs and integrated health care plans continued to lack consistent evidence of teams making data-based decisions. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

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

1. 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. (Section V.2)
2. Efforts should ensure that the staff responsible for conducting record audits are provided with necessary training, adequate guidelines and

criteria are included in the audit tools, and inter-rater reliability should be established. (Section V.3)

3. 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. (Section V.3)
4. 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. (Section V.4)
5. Efforts should be made to ensure that IDT members, as well as other appropriate staff, document in and utilize the Integrated Progress Notes in a manner that results in the provision of integrated, quality care to the individuals CCSSLC supports. (Section V.4)
6. As the Facility expands its self-assessment processes, for Section V.4, a number of different methodologies, including, for example, interviewing staff, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. (Facility Self-Assessment, and Sections V.3, and V.4)
7. Further refinement of the internal auditing process should occur, including establishment of inter-rater reliability, analysis of audit results, and development and implementation of corrective action plans. (Facility Self-Assessment)

List of Acronyms

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
ADLS	Assessment-Discussion-Skill Plan Link
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AED	Antiepileptic Drug
AED	Automated External Defibrillator
AFO	Ankle Foot Orthotic
ALS	Adult Life Skills
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APEN	Aspiration Pneumonia Enteral Nutrition
APS	Adult Protective Services
ASHA	American Speech and Hearing Association
AT	Assistive Technology
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
BMP	Basic Metabolic Panel
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
c	With
cc	Cubic Centimeters
CCC	Competency of Clinical Certification
CBC	Complete Blood Count
CCSSLC	Corpus Christi State Supported Living Center
CD	Communication Dictionary
C-Diff	Clostridium difficile
CDC	Centers for Disease Control

CEU	Continuing Education Units
CIP	Crisis Intervention Plan
CIR	Client's Information Record
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
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Aide
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CPE	Comprehensive Psychiatric Evaluation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTD	Competency Training Department
CV	Curricula Vitae
CWS	Certified Wound Specialist
DADS	Texas Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
d/c	Discontinued
DCP	Direct Care Professional
DEXA	Dual-energy x-ray absorptiometry
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DM-ID	Diagnostic Manual of Intellectual Disability
DPN	Dental Progress Note
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
ECFMG	Educational Commission for Foreign Medical Graduates
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
FACCWS	Fellow of The College of Certified Wound Specialists
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FDA	Federal Drug Administration
FNP	Family Nurse Practitioner
FSA	Functional Skills Assessment
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GFR	Glomerular Filtration Rate
GI	Gastrointestinal
G-tube	Gastrostomy tube
G/J-tube	Gastrostomy/Jejunostomy or transgastric feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HDS	Home Dining Supervisor
Hgb A1C	Hemoglobin A1C
HIV	Human Immunodeficiency Virus
HMP	Health Management Plan
HMT	Health Monitoring Tools
h/o	History of
HOBE	Head of Bed Elevation
HRC	Human Rights Committee
hs	At night
HT	Habilitation Therapies
IBWR	Ideal Body Weight Range
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ICST	Integrated Clinical Services Team
ID/DD	Intellectual Disabilities/Developmental Disabilities
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IHCP	Integrated Health Care Plan

ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intramuscular
IM	Incident Management
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter-observer Agreement
IPN	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITC	Integrity Treatment Checklists
IV	Intravenous
J-tube	Jejunostomy feeding tube
LA	Local Authority
LAR	Legally Authorized Representative
LON	Level of Need
LOS	Level of Supervision
LVN	Licensed Vocational Nurse
LRA	Labor Relations Alternatives
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
MRI	Magnetic Resonance Imaging
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
n	Sample of the Population Audited
N	Total Population Being Reviewed
NADD	National Association of Dual Diagnosis
NCP	Nursing Care Plan
NM	Nutritional Management
NMT	Nutritional Management Team
NOO	Nursing Operational Officer

NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPO	Nothing by Mouth
NSAID	Non-Steroidal Anti-Inflammatory Drugs
O2	Oxygen
OCD	Obsessive Compulsive Disorder
OHR	Oral Health Rating
OIG	Office of Inspector General
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
PCN	Program Compliance Nurse
PCP	Primary Care Practitioner
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
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
PNMPC	Physical and Nutritional Management Plan Coordinator
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)
PSI	Preferences and Strengths Inventory
PSR	Psychiatric Services Review
PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Assistant
RAT	Review Authority Team
RATM	Review Authority Team Meeting
RCP	Respiratory Care Practitioner
REACT	Respiration, Energy, Alertness, Circulation, and Temperature

RD	Registered Dietician
RN	Registered Nurse
RO	Rule Out
ROM	Range of Motion
RPC	Restrictive Practices Committee
RPH	Registered Pharmacist
RRC	Restraint Reduction Committee
RT	Respiratory Therapist
RTT	Residential Treatment Technician
q	Each
QA	Quality Assurance
QA/QI	Quality Assurance/Quality Improvement
QDRR	Quarterly Drug Regimen Review
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
Sd	Discriminative Stimuli
SEPR	Supplemental External Peer Review
SFBA	Structural Functional Behavior Assessment
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SLPA	Speech Language Pathology Assistant
SOAP	Subjective, Objective, Assessment, and Plan
SPO	Specific Program Objective
SRB	Socially Responsible Behavior
SSLC	State Supported Living Center
SSO	Staff Service Objective
Stat	Immediately
STD	Sexually-transmitted disease
UGI	Upper Gastrointestinal
UI	Unusual Incident
UIMRT	Unit Incident Management Review Team
UIR	Unusual Incident Report
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
TWR	Temporary Work Reassignment
UA	Urinalysis
UTI	Urinary Tract Infection
VFS	Video Fluoroscopy Study
VNS	Vagal Nerve Stimulator
WAIS	Wechsler Adult Intelligence Scale
WBC	White Blood Count
WC	Wheel Chair