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 this report indicates, at Corpus Christi State Supported Living Center (CCSSLC), since the Monitoring Team's last visit, there had been some notable areas of progress. Some departments were at the point of needing to ensure that implementation occurs at the direct support professional level. In other areas, very importantly, leadership staff were able to identify next steps to address outstanding issues. However, there also were some areas where important changes that impacted individuals' health and safety had not occurred, and it was not clear there were plans to address these areas. At this point in the life of the Settlement Agreement, it is essential that these issues be addressed.

As with previous reviews, the Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at CCSSLC for their assistance during the onsite monitoring visit, as well as in preparation before the visit, and the production of many documents after the visit. Everyone with whom the Monitoring Team spent time during the onsite review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

The following is a brief summary of CCSSLC's status with regard to relevant sections of the Settlement Agreement:

Restraints

- The Facility had made progress in the management of the use of restraints, including:
  - A policy change specified abdominal binders as an approved restraint device.
  - Progress had been made on fading the use of abdominal binders.
  - Use of restraints for crisis intervention appeared to be continuing to decline, but because the Facility had modified how it counted restraints over time, clear comparisons could not be made.
- Some areas were identified that need attention, including:
  - The Restrictive Practices Committee should continue to work to achieve good attendance at meetings and to document discussions and decisions in the meeting notes.
  - Dates of reviews by the Unit and the Incident Management Review Team (IMRT) need to be documented on the Restraint forms.
  - Unit Team and IMRT minutes need to reflect consideration of the accuracy of the documents presented, whether there is a need for the Interdisciplinary Team (IDT) to meet to address any issues, and whether there are any other recommendations that need to be addressed.
  - The electronic forms need to be adjusted to assure that needed text can be included and will print when necessary.
  - Key indicators of performance need to be identified to track progress.
  - When medical/dental restraints are used, the physician needs to specify the type of frequency of monitoring that is to be done, and the monitoring needs to be carried out as ordered.

Abuse, Neglect and Incident Management

- Progress was noted in a number of areas. Highlights of progress included:
  - Unusual Incident Reports (UIRs) had been improved through the use of new Adobe software to allow more flexibility in moving information from the Department of Family and Protective Services (DFPS) report to the associated UIR and through reducing unnecessary duplication between the two reports.
- Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to:

- Solve the problem of completing UIRs on time and when a report could not be done on time, requesting an extension.
- Establish the processes for auditing injuries and completing investigations of trends of injuries or trends of peer-to-peer injuries, or patterns of injuries discovered either through the audit process or through the monthly reviews of trend data.
- Load the quality assurance (QA) monitoring data into the system so that it can be compared with the Incident Management Coordinator (IMC) unit data to establish a healthy check on performance.
- Include the history of alleged perpetrators in the UIR or include the list in the record.
- Assure that documentation of the review of investigations includes comments and directions for follow-up when necessary, and that the follow-up is tracked to conclusion.

<u>Quality Assurance</u>

- Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including:
  - The QA Plan had been modified to add details about corrective action plans, action plans, and the Quality Assurance/Quality Improvement (QA/QI) Council.
  - There were more Corrective Action Plans (CAPs) than in past reviews, and it was noted that the Facility Director was encouraging staff to consider CAP development when issues arose during the QA/QI meeting that members of the Monitoring Team observed.
  - The QA/QI meeting included some data presentations and use of data to drive decisions and to help hold people accountable for completing assessments.
  - QA/QI Council meetings included a review of outstanding assessments, tracking of attendance at Individual Support Plan (ISP) meetings, and an Integrated Risk Rating Form (IRRF) status report.
- Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included:
  - A list of key indicators was under development, but it was not clear that the list was finalized, what data was being collected, or how the data for the key indicators would be managed, reported, or addressed.
  - The QA Director needed to take a more direct role in the QA/QI meeting, perhaps providing an overview each month based on the matrix to indicate which sections had completed monitoring, which did not, and where issues were arising in the QA process.
  - The monitoring tool for Section E needed revision to provide a valid assessment of progress toward substantial compliance.
  - The CAPs tracking needed to include the method and dates of dissemination, and should not rely on minutes of meetings to convey CAP assignments.
  - A system was needed to measure whether or not CAPs were achieving the desired outcomes, and, if not making revisions to the plans.

Integrated Protections, Services, Treatments and Supports

- CCSSLC continued to develop and implement training to improve the Individual Support Plans (ISPs) for the individuals it served, as well as to take other steps to develop integrated plans. Some examples included:
  - In June 2013, the Qualified Intellectual Disabilities Professional (QIDP) Coordinator provided training to interdisciplinary teams (IDTs) on each of the Units. Scenarios were used to prompt discussion from the teams about writing ISPAs, including related action plans. This was an innovative approach to try to expand teams' skills in this area.
  - In August 2013, all IDTs participated in training on the At-Risk process that CCSSLC had developed. It incorporated information about the general ISP process, as well as in-depth information about the IRRF and IHCPs. As noted above, it provided a good structure for teams to use when developing action plans.
  - In May 2013, the Programming Review Committee began meeting. This was an example of good coordination between the QIDP and Active Treatment Departments. The group met weekly and reviewed two individuals' ISPs and monthly reviews. Based on observation during the week of the onsite review, this offered a respectful peer review opportunity for the monthly reviews and ISPs. The Facility is encouraged to continue this practice and even expand the scope of the review to include additional requirements for a comprehensive ISP, such as the quality of action plans.
  - Timeliness of assessments as well as 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.
- The following are some of the areas in which concerted efforts were needed to move towards substantial compliance:
  - 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.
  - 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.
  - The Facility recently was using the Integrated Health Care format, which often 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.
  - Action plans included more measurable action steps, which was positive. Although some limited improvement was seen, 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 recognized this was an area needing improvement, but 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 QIDP and QA Departments continued to work together to revise the tools they used to monitor ISP meetings, as well as ISP documents. Since the last review, they had made good progress on developing guidelines for the tools, but these still required refinement. Efforts were in the initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development.

Integrated Clinical Services

- The Integrated Clinical Services Team (ICST) meeting developed a structure for presenting various clinical services. With this structure in place, further development of the full potential of this process was possible. Attendance was measured, and included representation by several departments. However, better time management will be important in order to include discussions of prevention of hospitalizations and Emergency Room (ER) visits, as well as review of open record reviews and ISPAs. In order to make findings available for the ISPA process, timely completion of the open record review will need focused attention and monitoring.
- Individual Support Plan Addenda (ISPAs) appeared to be completed late for many post-hospital reviews. Many of the ISPAs did not address preventive steps, and the ICST meeting should review and return these to the Interdisciplinary Team (IDT) for further documentation of preventive steps.
- Tracking of the consultant recommendations and follow through by the Primary Care Practitioner (PCP) appeared to be thorough and accurate, but standards for when IDTs needed to review the consults and consider further action were needed.

Minimum Common Elements of Clinical Care

- The Medical Department identified that timely annual medical assessment and quarterly medical review completion needed continued focus. Dental assessments were completed timely. Timely completion of other discipline assessments for the ISP process had different data sets with different findings.
- The samples of active records included sufficient criteria for justification of the major medical and psychiatric diagnoses in the record.
- The Medical Department followed the corrective action plans for the medical management audit. The internal quality indicators the Medical Department used for monitoring provided evidence of significant advancement in this area. Several diagnoses were included, and baseline and serial results were provided. The analysis of results was not clear at times. For those questions on the audit reaching 100 percent repeatedly, there was no information concerning substituting other clinical indicators to continue to challenge the system.

At-Risk Individuals

- At the time of the review, the Facility was in the process of identifying key compliance indicators for Section I in alignment with the Settlement Agreement and based on the elements the Monitoring Team reviews. A review of

the identified indicators contained in the Facility's Presentation Book for Section I found them to be very promising in reviewing a number of aspects regarding the At-Risk system. In addition, the Facility appropriately revised its monthly monitoring tool for Section I in alignment with the elements of the Settlement Agreement and Monitoring Team's indicators and to accurately identify the Interdisciplinary Teams' areas of strengths and weaknesses regarding the ISP process.

- From the Facility's monitoring activities and deconstruction of a number of elements of the At-Risk system, the Facility developed an exceptional Facility training curriculum course that clarified a number of questions and areas of confusion that the teams were found to have regarding the At-Risk process. At the time of the review, the Facility's Self-Assessment indicated that in August 2013, 89% (107 of 120) of the staff required to attend had attended the training.
- It was positive that the Facility indicated that the specific disciplines would be participating in auditing the quality of the discipline-specific documentation and assessments required by the system. However, there was much work yet to be done to ensure that criteria such as nursing protocols and clinical guidelines/pathways are included in the instructions of any auditing tools developed and implemented. This is necessary to accurately assess compliance for any items addressing the quality of the documentation.
- Although the Facility clearly had invested a great deal of effort in clarifying and training staff regarding the At-Risk system at CCSSLC, the overall lack of clear documentation included in the ISPs, the IRRFs, the Integrated Health Care Plans (IHCPs), 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 addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes.
- 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>

- At the time of the Monitoring Team's previous review, the Facility recently had employed a full-time locum tenens Psychiatrist, as well as a full-time Board Certified Psychiatrist who assumed the position of Chief Psychiatrist. The Consulting Psychiatrist also continued for eight hours per week. Since the Monitoring Team's previous review, the locum tenens Psychiatrist had left the Facility. At the time of the current review, the Consulting Psychiatrist continued to supply the direct psychiatric services to the individuals residing at CCSSLC through the Psychiatric Clinics, while the Chief Psychiatrist assumed the responsibility for completing and updating the Comprehensive Psychiatric Evaluations (CPE), performed Psychiatric Consultations as needed, and also attended to the numerous administrative responsibilities. The Psychiatrists continued to be supported by

two full-time Psychiatric Nurses and two Psychiatric Assistants, who provided the infrastructure necessary for the Department to continue to make progress.

- During the Monitoring Team's previous review, one of the challenges that confronted the Psychiatry Department was the integration of the clinical material, described in Section J.8, Section J.9, and Section J.10 into the ISP documentation. The Facility's plan at that time was to include information from the newly developed PMTP with the IRRF documentation that would be sent to the IDT for discussion at the ISP Preparation meeting, as well as the annual ISP meeting. In addition, at the time of the previous review, the Department was beginning an initiative that would enable a member of the Psychiatry Team to participate in the discussion of this material at the individuals' annual ISP meetings. These initiatives were designed to address the requirements to integrate relevant aspects of the individuals' Psychiatric Treatment Plan into the ISPs. The Facility's internal data indicated that after April 2013, a member of the Psychiatry Department attended 95 percent of the ISPs for individuals prescribed psychotropic medication. This was a positive development, but more work was needed to ensure that teams had discussions and documented the necessary deliberations related to the use of psychotropic medications and alternatives.
- Another major challenge was the continued high rates of polypharmacy. At the time of the last review, the Psychiatry Department had begun to organize this data on a categorical basis to enable the Psychiatric Team to both assemble and then effectively present the necessary historical information to justify the continued use of medication. Since then, this initiative had been completed and provided the necessary information for a significant number of these individuals.
- CCSSLC had maintained thorough documentation of the symptoms needed to establish the individual's psychiatric diagnosis, as well as the differentiation of those behaviors derived from the psychiatric diagnosis, as opposed to those present on a behavioral basis. The Chief Psychiatrist had assumed the responsibility for completing and updating the CPEs, and had brought the completion rate for updated CPEs back to a 100 percent completion rate.

<u>Psychological Care and Services</u>

- Behavioral Health Services Providers 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. However, despite this progress, recent changes within the leadership of the department significantly changed the provision of services by BCBAs. That is, at the time of the visit, the top two leadership positions within the Behavioral Health Services Department were vacant and no clinical supervision was in place for the members of the Behavioral Health Services Department.
- Since the Monitoring Team's last visit, progress was not conspicuous in the area of internal peer review within Behavioral Health Services Department. However, some progress was noted in the area of external peer review.
- Progress continued to be observed in the completion of psychological assessments, including the completion of standardized tests of intelligence and tests of adaptive behavior as well as in the increasing use of the

comprehensive psychological evaluation format. However, concerns were noted with the completion of assessments for newly admitted individuals.

- Progress continued to be evident in the area of data collection and ongoing progress monitoring, including data display. Although progress was noted, concerns about the adequacy of data collection, including its flexibility and timeliness as well as reliability remained.
- Efforts were noted with regard to the development of improved Positive Behavior Support Plans (PBSPs). However, concerns regarding the adequacy of staff instructions, receipt of consent, and timeliness of implementation were noted. In addition, concerns were noted with regard to the provision of services to individuals requiring psychological services other than PBSPs, including the provision of counseling services.

Medical Care

- The Medical Department had made significant progress with numerous initiatives:
  - The structure for the ICST meeting had been established, and routine updates by various members from clinical departments were included. However, the structure was in the early stages of implementation, and more work was necessary to ensure important topics were covered thoroughly, and teams developed appropriate follow-up ISPAs, particularly for hospitalized individuals.
  - Several guidelines and protocols had been developed, including early aggressive treatment of unstable vital signs.
  - Preventive care was one of the Medical Department's strengths, especially with the recent addition of gynecological services, as well as completion of such procedures as mammograms and colonoscopies.
  - The internal quality audits appeared rigorous and current, and covered several diagnoses common to the Intellectual Disabilities/Developmental Disabilities (ID/DD) population.
- There were numerous challenges remaining:
  - Some of the databases had conflicting data.
  - The ICST needed to ensure timely completion of open record reviews and reviews of ISPAs.
  - The quality of the ISPAs the ICST requested needed review.
  - The annual medical assessments needed to include a discussion of the risk categories used in the IRRF.
  - Some protocols, such as secondary causes of osteoporosis had not been implemented.
  - In addition to timely completion, quarterly medical reviews needed standardization of content and focus efforts to improve the value and utility of the information included.
  - Reduction in missed specialty appointments should be considered a priority.
  - Do Not Resuscitate (DNR) Order status required further research to determine whether there was justification or not.
  - The Facility had many databases that could be used to guide quality improvement initiatives in the Medical Department. It will be important to document the analysis of information in each of these

databases, and then develop and implement action steps, and review outcomes to determine the effectiveness of the corrective actions.

Nursing Care

- Some of the Facility's positive steps forward included:
  - The reliability of the Infection Control (IC) data continued to improve as reflected in data generated from comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics.
  - The documentation contained on the Outbreak Reports regarding outbreaks of Influenza A and Scabies that occurred since the last review was detailed. The reports included specific clinical information regarding the individuals' status and progress, as well as any treatments initiated and precautions implemented. In addition, it indicated the IC Nurses provided a number of timely in-service training sessions to staff in response to the outbreaks and followed all cases reported to resolution.
  - The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at King Fish and Sea Horse found that all the nurses observed 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 in this area.
- Although the Facility had made some positive steps forward in the areas noted above, the overall continued lack of progress found regarding the 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 to the Monitoring Team at this juncture in the review process.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department developed rigorous internal audits for many areas of pharmacy services, including new order reviews, and Quarterly Drug Regimen Reviews (QDRR) content. Many aspects of the QDRRs were well done, including the anticholinergic section in addressing risks versus benefits.
- There had been numerous initiatives to assist in reducing the medication variances at CCSSLC. However, numerous challenges remained. Perhaps one of the more significant concerns was the number of vacancies in the Pharmacy Department. There was only one full-time pharmacist and one part-time contract pharmacist, along with the pharmacy technicians, to complete numerous administrative and system duties, along with ensuring appropriate dispensing and accountability of medication. The Facility needs to urgently provide assistance in filling the existing vacancies with quality pharmacy personnel.
- Many of the findings indicated gaps, such as lack of the quarterly Pharmacy and Therapeutics (P&T) Committee meeting in July, lack of completion of the Drug Utilization Evaluations (DUEs), lack of timely reporting of Adverse Drug Reactions (ADRs) to the P&T Committee, delays in reporting ADRs to the pharmacy, and incompleteness of the single patient intervention notes in WORx. Medication variances remained numerous,

and Pharmacy Department will need to develop further system approaches to determine the source of these medication variances to reduce the volume of errors.

Physical and Nutritional Supports

- The Facility's Physical and Nutritional Management Team (PNMT) had the required core members as outlined in the Settlement Agreement, and was meeting regularly. Medical providers attended the IDT/PNMT meeting to discuss the findings of the PNMT assessment.
- The DADS At-Risk, Physical Nutritional Management (PNM), and Quality Assurance policies and multiple CCSSLC policies/protocols were comprehensive and included necessary PNM policy elements.
- Individuals who met the PNMT referral criteria had not been consistently referred to the PNMT. However, for those individuals that had been referred, the PNMT members had made substantial progress in the completion of comprehensive PNMT assessments.
- Additional work also needed to be done to integrate PNMT recommendations in IHCPs and, most importantly, implement them.
- Since the Monitoring Team's last review, progress continued to be made with individuals' Physical and Nutritional Management Plans (PNMPs) having more of the necessary elements. The Facility had developed and implemented a process that alerted staff to PNMP revisions and their responsibility in the implementation of an individual's PNMP when revisions had been made.
- The Monitoring Team, the PNMT Occupational Therapist (OT), and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. A mealtime observation in the Coral Sea dining room showed excellent implementation of the PNMPs. Individuals were correctly positioned in their wheelchairs, prescribed adaptive equipment was present, staff were following dining plan presentation techniques, and communicating with individuals during the meal. However, observations in the Infirmary, in the Pacific dining room, and in other parts of the residences in Pacific and Coral Sea revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk.
- Individuals were not monitored for the effectiveness of their progress in relation to their physical and nutritional management needs, nor was evidence provided that interventions were modified if an individual was not making progress. More specifically, the implementation of individuals' IHCPs did not generate individual-specific clinical data to substantiate individuals' progress or to assess if the individual was better or worse. 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 their IDTs. However, the annual assessment did not include necessary elements. Individuals who were transitioning to oral eating did not have formal plans.

Physical and Occupational Therapy

- Individuals newly admitted to the Facility received an OT/PT assessment within 30 days. Since the last review, the Facility's OT/PT assessment content had improved. An OT/PT assessment audit tool had been developed and implemented. Individuals' OT/PT assessments were missing some of the required elements, and additional work was needed to ensure necessary assessments elements were completed. There were individuals who had experienced a change in status with an admission to the Infirmary and/or community hospital with PNM-related concerns who had not received an assessment update.
- Some individuals receiving direct OT/PT therapy interventions did not have plans. As a result, these plans and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes had not been completed to review 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, the Facility did not have an adequate monitoring system for PNMPs. However, the Facility did have the foundation in place for a sustainable system to monitor individuals' prescribed adaptive/assistive equipment.

Dental Services

- The Dental Department was well-organized department and provided a breadth of dental services. Databases were available to track each of the main aspects of dental care. These databases appeared current and accurate. The Dental Department had ongoing support of the data analyst in developing the databases and measurements needed for tracking baseline services and progress. The Dental Department demonstrated that they had used this information to improve the dental services. The Dental Department had been able to identify areas of need and challenge, and had already begun to act on these areas, prior to the Monitoring Team's visit.
- There were a few areas of concern or challenge remaining. Constant attention to training of new employees, as well as confirming completion of refresher courses by staff was an ongoing challenge. The database tracking appeared to be thorough. Continuation of the development of desensitization programs as well as tracking of success with the skill acquisition plans and staff supported objectives needed continued focus and ongoing support from all departments. In an administrative area, the Dental Department had 40 policies in draft phase, which needed to be completed, approved, trained, and implemented. Additionally, as noted in examples provided with regard to Section I, it was problematic that the IDT (including the dental representative) documented that dental supports were adequate for individuals having recently undergone extractions or having poor oral hygiene ratings. When applicable, the Dental Department needed to assist and direct the IDT in identifying additional supports for these individuals with undesirable outcomes in oral health.

Communication

- The Facility Lead Speech Language Pathologist (SLP) indicated that a time study had been initiated to assess SLPs' time commitment and workload related to the completion of assessments, the development and implementation of programs, provision of staff training, and monitoring implemented programs. The results of

the time study had not been finalized. As a result, it remained unclear how the Facility had determined what an appropriate caseload would be for SLPs at CCSSLC, and the current caseload assignments far exceeded even the general rule that State Office had identified.

- The Facility had made substantial progress with individuals' communication assessments. Individuals' speech language (SL) assessments within the sample included the majority of necessary elements.
- ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use alternative and augmentative communication (AAC) devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress.
- Individuals who received direct SL therapy interventions had their plans initiated in a timely manner. However, monthly progress notes did not include necessary elements.
- Observations of individuals with AAC systems revealed individuals' systems were present and/or being used, were portable and functional, and staff were able to locate and discuss staff instructions. These observations were a substantial improvement over observations during the Monitoring Team's previous reviews.
- Competency performance check-offs had been developed and implemented for individuals' staff requiring individual-specific training on their AAC devices. In addition, staff instructions for these devices described how to maintain the devices (e.g., replacement of batteries). However, the Monitoring Team was not able to ascertain if all required staff had successfully completed individual-specific performance check-offs.

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

- Continued effort and progress was noted with regard to the skill acquisition plans (SAP) format, including dental desensitization plans. Although some improvement was noted in developed SAPs, concerns regarding their overall quality remained.
- The level of engagement the Monitoring Team estimated was less than expected given previous estimates. In addition, lower than expected rates in the completion of engagement estimates by the Facility was concerning. However, changes in the method of collecting engagement data appeared promising.
- The ongoing collection and dissemination of attendance data appeared likely to facilitate improved work and program attendance.
- Progress was noted in the systems that support the adequate completion of assessments that examine individuals' preferences, strengths, skills, needs, and barriers to community integration. However, as related changes take time to occur, concerns regarding the adequacy and/or timeliness of sampled assessments remained. Progress was noted with regard to the number of individuals experiencing situational assessments and/or vocational explorations.
- Progress was noted with regard to monitoring skill acquisition through the use of Monthly Reviews. One related highlight was the initiation of the Program Review Committee. In addition, efforts to improve the systems used

to review skill programs, train competent trainers, and ensure adequate data collection were noted. However, the Facility will need to ensure adequate opportunities for skill acquisition in the community.

Most Integrated Setting

- 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 or justify the obstacles to referral. In addition, although teams were developing action plans to address obstacles to referral, they were not individualized.
- In reviewing CLDPs, at least two individuals were returning to CCSSLC to participate in the work/vocational program, and providers were working to identify vocational supports for them in the community (i.e., Individual #94 and Individual #112). 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, supports, 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 provision of pre- and post-move supports, and substantiate the findings (e.g., interviews, document reviews and observations). The QA Nurse had been identified as a resource for the Post-Move Monitor for individuals moving to the community with more extensive medical and physical and nutritional support needs. This was a positive development in bringing more clinical expertise to the post-move monitoring process. In addition, progress had been made in involving IDTs in the Facility's efforts to take reasonable action to correct deficiencies noted.

Consent

- At the time of the review, the State Office policy on consent had not been issued. The State 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."
- As noted in the previous two reports, 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 7/31/13. It included a total of 248 names. Of these, 155 individuals were identified as adults with no guardians, but needing guardians. This group included 41 individuals with a Level 1 priority need for guardianship (the highest level), 93 with Level II priority need, and 21 with Level III priority need. Another 89 individuals were identified as adults with guardians, and an additional four had no priority level for guardianship (i.e., these individuals appeared to be newly admitted to CCSSLC).
- The Facility recognized the need to use a more objective process to determine individuals' priority level in terms of their need for a guardian. As a result, CCSSLC had begun to draft a revised version of a rating tool obtained from another SSLC. Based on review of the Draft Guardianship Priority Discussion, dated 8/21/13, a number of questions arose. It will be important for the Guardianship Committee to better define objective (i.e., measurable) criteria, as well as to provide clear guidance to teams on the use of this tool, and in particular, its relationship with specific assessments.
- 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.
- The Facility's Guardianship Committee had continued to meet regularly. Since the last review, additional external members had joined the group, which was a positive step forward.

Recordkeeping and General Plan Implementation

- CCSSLC continued to maintain Active Records as well as Individual Notebooks. Since the last review, all individuals' had been converted to a revised Table of Contents that State Office issued.
- 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 the time of the last review, a method was being developed to accurately track staff's training on policies. At the time of this most recent review, the Competency Training Department (CTD) had a process to for tracking the completion of training, and was able to send reminders to staff who had not yet

completed the training. The Administrative Programs Specialist also assisted with training follow-up, and reported the training status to the QA/QI Council.

- CCSSLC was conducting the required five records each month. A Program Compliance Monitor from the QA Department also involved in the process. While the Monitoring Team was on site, the Unified Records Coordinator modified the spreadsheet used to collect data on the audits. With these modifications, the very specific information collected about each record reviewed could be aggregated. This should significantly assist in trending the data and identifying issues that specific disciplines or residences might need to address, or for which the Facility might need to develop and implement more systemic actions.

VI. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** ▪ **Review of Following Documents:** o Procedure C.8: Protection From Harm – Restraints, dated 5/3/13; o Policy: Use of Restraint (PowerPoint presentation for "train the trainers" on 2012 restraint policy), approved April 2012, revised 6/10/13; o Restrictive Practices Committee Minutes: 3/1/13 to 7/30/13, and 9/30/13; o List of Restraint Monitors from 2/1/13 to 7/16/13; o CCSSLC Restraint Monitors 7/16/13 to 7/31/13; o List of Nurse Monitors trained, undated; o Nursing Procedure: Assessment of Vital Signs, May 2011; o Quality Assurance/Quality Improvement (QA/QI) Council Meeting Minutes: 3/7/13 to 8/1/13; o **Sample #C.1**: Chosen from list individuals restrained between 2/1/13 and 7/31/13 per II.7 of document request. The list included 125 incidents of crisis restraint. A sample of 19 (15%) of the restraint episodes was drawn and included both physical (14) and chemical (5). Documents included: • The Restraint Checklist; • The face to face/debriefing report; • The crisis intervention plan (CIP); • Positive behavior support plan and • Any/all reviews of this use of restraint (Including Unit Team, Incident Management Team, and Restraint Reduction Committee.

Sample Identification #	Individual Identification	Date and Time	Type
C1.1	Individual #253	5/28/13 at 2:59 p.m.	Physical
C1.2	Individual #253	5/30/13 at 7:54 a.m.	Physical
C1.3	Individual #253	7/2/13 at 7:41 a.m.	Physical
C1.4	Individual #253	7/2/13 at 7:35 a.m.	Physical
C1.5	Individual #253	7/2/13 at 7:33 a.m.	Physical
C1.6	Individual #275	6/12/13 at 5:00 a.m.	Physical
C1.7	Individual #275	7/9/13 at 9:30 a.m.	Physical
C1.8	Individual #297	7/15/13 at 10:08 p.m.	Physical
C1.9	Individual #297	7/15/13 at 9:30 p.m.	Physical
C1.10	Individual #297	7/15/13 at 9:50 p.m.	Physical
C1.11	Individual #169	4/17/13 at 11:41 a.m.	Physical
C1.12	Individual #169	6/10/13 at 4:13 p.m.	Physical
C1.13	Individual #191	6/26/13 at 6:26 a.m.	Physical
C1.14	Individual #172	6/12/13 at 9:09 a.m.	Physical

C1.15	Individual #7	7/2/13 at 8:45 p.m.	Chemical
C1.16	Individual #275	3/13/13 at 2:04 p.m.	Chemical
C1.17	Individual #348	2/11/13 at 4:15 p.m.	Chemical
C1.18	Individual #238	2/14/13 at 8:15 p.m.	Chemical
C1.19	Individual #40	3/2/13 at 7:22 p.m.	Chemical

- **Subsample of C.1:** A subsample of three records from #C.1 for use in section C.4.e and f. Documents included:
  - Medical Summary Active Problems list;
  - The form used by the Facility to document restraint considerations/restrictions;
  - ISPs/ISPAs indicating that restraint considerations that have been identified by any member of the IDT have been addressed and documented.

Sample #	Individual Identification	Date and Time	Type
C1.1	Individual #253	5/28/13 at 3:07 p.m.	Physical
C1.6	Individual #275	6/12/13 at5:00 a.m.	Physical
C1.13	Individual #191	6/26/13 at 6:36 a.m.	Physical

- **Sample #C.2**: The following documentation was requested for a selected sample of 24 staff:
  - Their start dates;
  - 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;
  - The signed forms to show that each identified volunteer had acknowledged his/her responsibility to report abuse/neglect; and
  - Evidence of training.
- **Sample #C.3**: was chosen from the list provided in response to document request II.7b of 53 restraint reports for medical and dental restraint involving 19 individuals. The sample of 10 restraint reports (19% of the restraint episodes) was drawn representing nine individuals or 47% of the individuals restrained. The documents included:
  - The restraint checklist;
  - Documentation of the monitoring of the restraint;
  - Any reviews of the use of restraint;
  - Any desensitization plan or other plan to reduce the use of restraint that may apply;
  - The physician's order for the restraint, including the monitoring schedule to be used; and

- The medical restraint plan.

Sample #	Individual Identification	Date
C3.1	Individual #153	6/11/13
C3.2	Individual #153	5/2/13
C3.3	Individual #369	4/10/13
C3.4	Individual #348	7/31/13
C3.5	Individual #221	4/30/13
C3.6	Individual #235	5/21/13
C3.7	Individual #83	3/8/13
C3.8	Individual #194	4/4/13
C3.9	Individual #198	7/11/13
C3.10	Individual #256	6/14/13

- **Sample #C.4**: Chosen from II.7 in response to the document request. The total number of chemical restraints for crisis intervention was eight. Sample size was five, or 63%. Note that these are also part of Sample #C.1 above.

Sample Identification #C4 (Also C1 chemical)	Individual Identification	Date and Time
C1.15	Individual #7	7/2/13 at 8:45 p.m.
C1.16	Individual #275	3/13/13 at 2:04 p.m.
C1.17	Individual #348	2/11/13 at 4:15 p.m.
C1.18	Individual #238	2/14/13 at 8:15 p.m.
C1.19	Individual #40	3/2/13 at 7:22 p.m.
Total = 5		

- For Section C.4: Positive Behavior Support Plans (PBSPs), as available, for: Individual #19, Individual #234, Individual #318, Individual #118, Individual #353, Individual #16, Individual #61, Individual #9, Individual #40, Individual #253, and Individual #238;
- **Sample #C.5**: There were no off-grounds restraints during the review period;
- **Sample #C.6:** includes three individuals who were restrained more than three times in a 30-day period, with a total of 13 restraints. The sample was selected from the list of individuals restrained as crisis intervention between February 2013 and July2013. Restraint records were requested and reviewed, including Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Reports, Crisis Intervention Restraint Plans (in place at the time of the identified restraints), Positive Behavior Support Plans (in place at the time of the identified restraints, including current PBSP if subsequent changes were made relative to restraint issues), Individual Support Plans, ISP Addendums, Monthly Behavioral Services Reviews (for the current month of the identified restraints as well as the month prior and the month following), as available, for the following individuals with restraints on the following dates and times as specified:

Individual	Date of Restraint	Time of Restraint
Individual #40	3/2/13	7:06 p.m. (physical)
	3/2/13	7:20 p.m. (physical)
	3/2/13	7:22 p.m. (chemical)
	3/2/13	7:27 p.m. (physical)
Individual #169	4/17/13	11:41 a.m. (physical)
	4/29/13	5:55 p.m. (chemical)
	4/29/13	4:56 p.m. (physical)
	4/29/13	5:19 p.m. (physical)
	4/29/13	5:27 p.m. (physical)
Individual #275	3/8/13	2:20 a.m. (physical)
	3/8/13	11:43 a.m. (physical)
	3/8/13	1:15 p.m. (physical)
	3/8/13	1:26 p.m. (physical)

- **Sample #C.7**: For three individuals restrained in protective mechanical restraint for self-injurious behavior (PMR-SIB), documents reviewed included:
  - The Restraint Checklist;
  - The face-to-face/debriefing report;
  - The documentation of monitoring of the restraint;
  - The order for the restraint and any alternate schedule of monitoring;
  - The ISP confirming the use of the restraint; and
  - Any and all reviews of the use of the restraint.

Sample Identification #	Individual Identification	Date	Type
C7.1	Individual #58	5/20/13	Mechanical
C7.2	Individual #9	6/20/13	Mechanical
C7.3	Individual #273	7/20/13	Mechanical

- Nursing Restraint documentation from the Restraint Checklists, Interdisciplinary Progress Notes, and Client Injury Reports for the following individuals:
  - Individual #253 on 5/28/13 at 2:59 p.m., 5/30/13 at 7:54 a.m., and 7/2/13 at 7:41 a.m.;
  - Individual #275 on 6/12/13 at 5:00 a.m., and 7/9/13 at 9:30 a.m.;
  - Individual #297 on 7/15/13 at 10:08 p.m.;
  - Individual #169 on 4/17/13 at 11:41 a.m., and 6/10/13 at 4:13 p.m.;
  - Individual #191 on 6/26/13 at 6:26 a.m.; and
  - Individual #172 on 6/12/13 at 9:09 a.m.

- **Interviews with**:
  - Mark Cazalas, Facility Director;
  - Brandon Riggins, Assistant Director of Programs;

	○ Judy Sutton, M.A., BCBA, Director of Behavioral Health Services, ○ Dr. George Zukotynski, State Office Coordinator for Behavioral Health Services; ○ Cynthia Velasquez, Director for Quality Assurance (QA); ○ Beverly Okin-Larkin, System Analyst; ○ Karen Ryder, Program Compliance Monitor for Section C; ○ John Henley, Unit Director for Atlantic; ○ Lindsay Hertz, Psychiatric RN; ○ Michelle Arteaga, Psychiatric RN; ○ Michael Robinson, RN-BC, MSN, Chief Nurse Executive (CNE); ○ Staff members from various residential locations; and ○ Individuals in various residential locations. ▪ **Observations of**: ○ QA/QI Council Meeting, on 10/3/13; ○ Restraint Reduction Committee, on 9/30/13; ○ Atlantic Unit Team Meeting, on 10/1/13; ○ Incident Management Team (IMT) meeting, on 10/1/13; and ○ Residences: #522A, #522B, #522C, #522D, #524A, #524B, #524C, and #524D.
	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 one of the eight sub-sections of Section C and with sub-parts a and e of Section C.7. The Monitoring Team found the Facility was in substantial compliance with Section C.3, but not with the subsections of C.7. Based on review of the Self-Assessment and related documentation: ▪ The Facility's Self-Assessment for Section C was based on samples of at least 20% of restraints for crisis intervention, medical/dental restraints and protective mechanical restraints for self-injurious behavior (PMR/SIB) for the period from 2/1/13 to 7/31/13. The Behavioral Services Department conducted these reviews. In addition, the Quality Assurance Department completed one to two monitoring tools per month for the period, and reported an 89% overall agreement between findings of the QA and Behavior Services Departments on the application of the tools. ▪ The monitoring tool, revised in January 2011, remained in use. ▪ Data were presented for each sub-section by month based on random samples. ▪ The Facility included action steps for each sub-section 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, for process or individual outcomes, were included in the Self-Assessment. There is further discussion of key indicators with regard to Section E, Quality Assurance, in 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 action steps related to the inclusion of descriptions of

	circumstances prior to the start of behaviors that resulted in restraint. ▪ Many of the notes in the "completion status" column in the Action Plans indicated "in process." To be useful, an indication of what "in process" meant was needed. For example: Action Step C.1.7.a read "Behavior Support Plans are consistently implemented to potentially prevent the need for restraints by using reliability checks to ensure proper implementation." The start date was 10/15/12, and the projected completion date was 12/1/13. The completion status was marked as "in process." It was not clear what was in process, and whether there had been progress toward completion during the preceding 11 months.
	Summary of Monitor's Assessment: The Facility had made progress in the management of the use of restraints, including: ▪ A policy change specifying abdominal binders as an approved restraint device. ▪ Progress had been made on fading the use of abdominal binders. ▪ Use of restraints for crisis intervention appeared to be continuing to decline over the past year. Data for at least three years were available, but were not useful for comparison over three years since the method for counting restraints had undergone several changes during that time. Some areas were identified that need attention, including: ▪ The Restrictive Practices Committee should continue to work to achieve good attendance at meetings and to document discussions and decisions in the meeting notes. ▪ Dates of reviews by the Unit and the IMRT need to be documented on the Restraint forms. ▪ Unit Team and IMRT minutes need to reflect consideration of the accuracy of the documents presented, whether there is a need for the IDT to meet to address any issues, and whether there are any other recommendations that need to be addressed. ▪ The electronic forms need to be adjusted to assure that needed text can be included and will print when necessary. ▪ Key indicators of performance need to be identified to track progress. ▪ When medical/dental restraints are used, the physician needs to specify the type of frequency of monitoring that is to be done, and the monitoring needs to be carried out as ordered.

<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</td><td>The Facility provided the following data, based on information contained in trend reports:
<table>
<tr><th>Type of Restraint</th><th>9/1/12 to 2/28/13</th><th>3/1/13 to 8/31/13</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>211</td><td>118</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>28</td><td>11</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>16</td><td>11</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>255</td><td>140</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.

TOTAL individuals restrained in behavioral crisis	23	27
Of the above individuals, those restrained pursuant to a Crisis Intervention Plan	10	7
Medical/dental restraints	103	98
TOTAL individuals restrained for medical/dental reasons	44	42

Prone Restraint

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.

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 19 restraint records for individuals in Sample #C.1, none (0%) showed use of prone restraint.

d. Based on questions with 10 direct support professionals, 100% were aware of the prohibition on prone restraint.

Other Restraint Requirements

e. Based on document review, the Facility and State policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; 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 18 of the 19 records (95%), there was documentation showing that the individual posed an immediate and serious threat to self or others. The one that was not adequate was sample #C1.16, where the individual was described as "aggressive" to staff with no additional explanation of how that aggression posed a threat.
- g. For the 19 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 14 (74%) contained appropriate

#	Provision	Assessment of Status	Compliance
		documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. The five that did not were sample #C1.6, #C1.8, #C1.9, #C1.15, and #C1.17. In each of these records there was no description of the events that led to the behavior that caused the restraint to be used. ▪ h. In 19 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, the information was provided via a checklist of interventions with no indications of effectiveness or the time during which the interventions were employed. When a PBSP was present, it was difficult to tell whether it had been employed as written without some description of the order in which the interventions were employed. As a result, while the basic information was in place, it was not useful in deciding how to modify restraint procedures to be more effective. Sample #C1.7 contained a better description of the use of graduated interventions in the debriefing section of the record where a sense of the order of interventions was described. ▪ i. Facility policies did identify a list of approved restraints. ▪ j. Based on the review of 19 restraints, involving 10 individuals, 19 (100%) were approved restraints. k. In 14 of these records (74%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Those that did not were the same as in C.1.g above, based on a lack of documentation of the events that led to the behavior. That documentation was needed to allow a determination if the PBSP had been followed, and whether there were measures that might have been taken to avert the behavior that led to restraint. l. Of the restraints of three individuals that were considered to be PMR-SIB by the Facility, the Monitoring Team reviewed three (Sample C.7). Of these, one (33%) followed State Office policy regarding the use, management, and review of PMR. • Samples #C7.1 and #C7.2: There was a plan in place for each which included scheduled release; one-to-one staffing was provided; and the restraint was monitored by staff, nurse, Behavior Health Specialist, and a restraint monitor at the beginning of the day. However, the Restraint Checklist did not provide documentation showing the releases and re-restraints as they occurred. The Individual Support Plan included data for a month indicating some progress, but the Restraint Checklist did not contain that data. • Sample #C7.3: involved use of an abdominal binder. A plan was in place, and in this case, the release and re-restraint codes were used making it possible to determine the length of time in restraint. According to the information provided by the Facility, this individual had his feeding tube removed and there was no	

#	Provision	Assessment of Status	Compliance
		longer a need for the binder. However, it was anticipated that he would have a new feeding tube installed, at which time the use of an abdominal binder would be reconsidered. At the time of the review the Facility reported that it now had only two people using protective mechanical restraint. Based on this review, the Facility remained out of compliance with this provision due to the lack of descriptions of events prior to the behavior that led to restraint, and the lack of documentation of restraint application and release for individuals in PMR-SIB. While the Facility deserved recognition for having fading plans in place for individuals in PMR-SIB, and for reportedly keeping the use of protective mechanical restraints low, it remained necessary to assure that staff were documenting the application and release of restraints on the restraint checklists as indicated in the plans.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 14 restraint records involving the six individuals in Sample #C.1, who were physically restrained, were reviewed. Of these, two of the individuals had Crisis Intervention Plans that defined the use of restraint and four did not at the time of the restraint. In three of the 14 restraint records, the restraint was ended when the restraint could not be maintained and these three records were eliminated from the sample. Of the eleven restraints remaining: a. For five restraints involving two individuals who had Crisis Intervention Plans: in two of the restraints (40%) sufficient documentation was included to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. For those that did not: ▪ In Sample #C.1.1, the restraint was held for eight minutes and released when the individual was calm. The CIP called for holding the restraint for two minutes after the individual was calm. ▪ In Sample #C.1.4, the restraint was not held for the two minutes beyond calm. ▪ In Sample #C.1.8, the CIP called for use of wristlets after five minutes in restraint, yet the restraint was maintained for seven minutes without using wristlets and without holding the restraint two minutes beyond calm. b. For six restraints involving four individuals who did not have Crisis Intervention Plans, six (100%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review, the Facility remained noncompliant due to the finding that Crisis Intervention Plans were not being followed as to release of restraint.	Noncompliance
C3	Commencing within six months of	The Facility's policies related to restraint are discussed above with regard to Section C.1	Substantial

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	the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	of the Settlement Agreement. Since the last review, the Facility had amended its Policy C.8 to include abdominal binders as restraints permitted at the Facility. a. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; and ▪ Adequate supervision of any individual in restraint. Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided in the Documents Reviewed section above. b. A sample of 24 current employees was randomly selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: ▪ 24 of the 24 (100%) had current training in RES0105 Restraint Prevention and Rules. ▪ 16 of the 16 (100%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training. ▪ 24 of the 24 (100%) had completed PMAB training within the past 12 months. ▪ 16 of the 16 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. c. Based on responses to questions, 10 direct support professionals answered the following questions correctly: ▪ What policies govern the use of restraint? (100%); ▪ Describe two verbal or redirection techniques (100%); ▪ Describe two approved restraint techniques (100%); and ▪ How would you supervise an individual in restraint? (100%). d. In 19 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Based on this review, the Facility was in substantial compliance with this provision.	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one	a. Based on a review of 19 restraint records (Sample #C.1), in 18 (95%) there was evidence that documented that restraint was used as a crisis intervention. The exception was Sample #C1.16, where the individual was described as "aggressive" without	Noncompliance

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	year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	explanation. b. A sample of 11 PBSPs were selected and reviewed to examine whether or not restraints were used for anything other than crisis intervention. Based on the PBSP Master List (i.e., "CCSSLC: Individuals with PBSP"), dated 8/23/13, this sample reflected approximately 9% of the total number of PBSPs currently in place (N=117). Of the 11 PBSPs reviewed, in 11 (100%), there was 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 earlier and reported in the Monitoring Team's previous reports, the Facility policy did not allow for the use of restraint for reasons other than crisis intervention. c. In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention, except for protective mechanical restraints for self-injurious behavior. d. In 19 of 19 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. Based on three records from Sample #C.1, listed under documents reviewed above as Subsample of #C.1: ▪ e. In three of three restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's 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. 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. During the onsite review, members of the Monitoring Team attended a meeting of the Facility's Pre-treatment Sedation Desensitization Committee. At that time, it appeared that the Committee had made significant effort to closely examine each individual case with regard to the determination of whether or not more intensive supports with regard to medical and/or dental desensitization were required. Specific information about the function of this Committee is discussed with regard to Section J.4 of the Settlement Agreement. Provided documentation reflected the Facility efforts to identify individuals who participated in desensitization activities, including those individuals who had formal skill	

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		acquisition plans (SAP), staff service objectives (SSO), or formal desensitization plans. For example, provided summary documentation revealed that most individuals had an oral hygiene SAP or SSO (e.g., tooth brushing, cleaning dentures, rinsing mouth). Evidence suggested that the Facility attempted to ensure the appropriateness of these programs by conducting direct observation. That is, examples of completed observations of SAP/SSO (i.e., using a "Toothbrushing SAPs/SSOs Observation Form") were provided. In addition, it appeared that the Facility monitored the current oral hygiene for all individuals as rated by dental staff (i.e., "CCSSLC Current Oral Hygiene Rating Report," dated 8/19/13) as well as the status of SAP/SSOs currently in place. It was unclear to the Monitoring Team how these hygiene ratings were utilized when determining the need for SAP/SSOs, because several individuals with "poor" ratings did not have programming currently in place. Documentation also evidenced completion of "desensitization trials" which consisted of dental staff following a rubric of prescribed steps (i.e., staff actions and individual responses typical during a dental visit) and recording individual performance following each step. According to verbal reports, these trials were completed in an effort to determine if individuals were candidates for formal dental desensitization plans, and, if so, they provided insight into which skills to target. Provided documentation included a summary listing (i.e., "CCSSLC Individuals with Desensitization Plans Desensitization Trials Between 2/1/13 and 08/19/13," dated 8/19/13). This list indicated that 47 individuals were assessed using this rubric across multiple trials. Indeed, it appeared that 145 trials in total were completed during this time period. It should be noted that only 14 of these individuals had formal desensitization plans in place when the assessment was conducted. As reported in the Monitoring Team's previous report, the number of individuals identified as having dental and/or medical desensitization plans changed dramatically over time. At the time of the Monitoring Team's last visit, this change was reportedly due to ongoing revision in the identification process and was predicted to change in the future. Currently, as described above, this process was still ongoing and verbal reports indicated that continued revision was likely to facilitate more effective identification going forward. Nonetheless, according to provided summary documentation (i.e., "Desensitization plans," TX-CC-1309-PH3), there were 14 individuals identified by the Facility as having a medical and/or dental desensitization plan currently implemented. Closer review of these plans indicated that six individuals only had a medical desensitization plan, while the remaining eight had both a medical and dental desensitization plan. Interestingly, all of these plans were implemented on August 1, 2013. A closer examination of a provided sample of these current desensitization plans was completed and specific findings are discussed with regard to Section S.1 of the Settlement Agreement.	

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		As reported in Section S.1, a small sample of medical and dental desensitization SAPs, in addition to a larger random sample of SAPs, were currently reviewed. Due to the fact the Facility was still in the planning and initial implementation phase of this process, this review of medical and dental desensitization SAPs focused primarily on the quality of SAPs and did not include an examination of related ISPs, consents, and data for those individuals within the sample (as described with regard to Section S.1). Based on the current review of sampled medical and dental desensitization SAPs: ▪ g. The following indicator was not evaluated during the current review, but will be during upcoming reviews: ___ (___%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • h. Zero (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • i. The following indicator was not evaluated during the current review, but will be during upcoming reviews: ___ (____%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled As described above, 14 individuals were identified by the Facility as having a formal medical and/or dental desensitization plan currently in place. The Monitoring Team compared this listing of individuals with a listing of those individuals identified by the Facility as regularly requiring restraint and/or sedation for medical and dental procedures ("TX-CC-1309-II.23, dated August 17, 2013). Of the 14 individuals identified above as having desensitization plans currently in place, only four (i.e., Individual #58, individual #310, Individual #211, and Individual #198) were identified as needing restraint or sedation. It was unclear to the Monitoring Team why the remaining individuals with plans currently in place were not previously identified within this listing. In addition to the 14 individuals described above, the Facility more recently developed four additional desensitization plans using a revised format. That is, the Facility reportedly developed dental desensitization plans for Individual #83, Individual #119, Individual #67, and Individual #273 just prior to the Monitoring Team's onsite visit. These plans were to be part of an upcoming pilot scheduled to begin in late October 2013. Of these four, based on summary listings as described above, only Individual #83 was identified by the Facility as an individual who regularly required restraint and/or sedation for medical and dental procedures. As noted above, the reason(s) for the inconsistency between listings of identified individuals was unknown to the Monitoring Team. At this time, only one of these plans was available for the Monitoring Team's review. That is, only the dental desensitization plan for Individual #83 was provided for review. An examination of this plan was completed and specific findings regarding its	

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		quality are discussed with regard to Section S.1 of the Settlement Agreement. Based on this review, the Facility is not in compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	a. Review of Facility training documentation showed that modifications to the training curriculum for restraint monitors had been made as of 6/10/13. The modifications included clarification that restraint monitors could not perform as restraint monitor if they were involved in applying the restraint. This resolved an outstanding concern identified in the Monitoring Team's previous report. However, it was still not clear that restraint monitors were being taught how to review the restraint checklists to assure they contained a clear description of the circumstances (i.e., prior events, application and consequences) of the restraint. As a result, review of the Facility training documentation showed there was not an adequate training curricula for restraint monitors on the application and assessment of restraint. b. It was not clear that this training was competency-based, since the version provided did not include a test with case examples as the previous training had. c. Based on review of training records, 181 staff at the Facility who performed the duties of a restraint monitor had successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 19 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ d. In 12 out of 19 incidents of restraint (63%) by an adequately trained staff member. Records that did not contain documentation of this included: Sample #C1.2, Sample #C1.3, Sample #C1.4, Sample #C1.5, Sample #C1.15, Sample #C1.16, and Sample #C1.19. ▪ e. In 19 out of 19 instances (100%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. ▪ f. In 13 instances (68%), the documentation showed that an assessment was completed of the application of the restraint. While there was a Face-to-Face Assessment of the application of restraint in all records, there were inconsistencies in many of the records. Records that contained inconsistencies included: o Samples #C1.1, #C1.2 and #C1.3: the Level of Supervision (LOS) was listed on the restraint checklist as one-to-two, understood to mean one staff to two individuals. The Face-to-Face assessment indicated the staffing level was correct for restraint (i.e., one-to-one). Upon discussion with the Director of Behavioral Services, it was clear that the staffing level had been two staff for the individual. This should have been	Noncompliance

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		corrected on the Face-to-Face assessment. o Sample #C1.10: the time in restraint was recorded on the restraint checklist as 9:50 p.m. to 10:01 p.m. In the section of the checklist where the times in and out of restraint and the reasons were recorded, the restraint was documented as 10:29 p.m. and appeared to have lasted less than a minute. o Sample #C1.11: the Face-to-Face indicated the Behavior Health Specialist was contacted for a chemical restraint, but the restraint was physical. o Sample #C1.16: the Face-to-Face did not provide information on the nature of the aggression that caused the restraint that was missing from the restraint checklist, nor call attention to the fact that the information was missing. ▪ g. In 12 instances (63%), the documentation showed that an assessment was completed of the consequences of the restraint. Records that did not contain documentation of this included: o Sample #C1.1: inconsistency was noted between the restraint checklist where the nurse indicated no injury, and the Face-to-Face noted an injury, but checked N/A for nursing. An injury report was filed for an injury prior to the restraint. o Sample #C.1.2: it was not clear from the information on the checklist and the Face-to-Face whether there was an injury related to the restraint. o Sample #C.1.9: there was no explanation on the Face-to-Face about why the individual was not assisted to regain composure. o Sample #C.1.10: there were inconsistencies in the times of restraint release, yet the Face-to-Face indicated the restraint checklist had been completed correctly. o Sample #C.1.11: the Face-to-Face indicated that staff concerns were not addressed without explanation; o Sample #C.1.12: the restraint checklist indicated no injuries, but the Face-to-Face indicated there were injuries. o Sample #C.1.19: the Face-to-Face did not indicate whether staff emotions were addressed (the check box was left blank). Individually these inconsistencies might appear to be minor. However, the number of inconsistencies suggested that restraint monitors were not taking care to scrutinize the restraint checklists to assure accuracy. In turn, these inconsistencies made review of the restraint episodes more difficult, and if errors in application of restraint and concerns with consequences of restraint were not correctly identified, then action likely would not be taken to ensure individuals were appropriately protected from harm. A sample of three records for which physicians had ordered alternative monitoring	

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		schedules was reviewed. These were for individuals identified in the sample of use of PMR-SIB as described in section C.1.l above and identified as Sample #C7 in the list of documents reviewed. ▪ h. In three out of three (100%), the extraordinary circumstances necessitating the alternative monitoring were documented; and ▪ i. In one out of three (33%), the alternative monitoring schedules were followed. The indicator C.1.l above provides a description of issues with the documentation related to the monitoring schedules. Based on a review of 10 restraint records for six individuals for restraints that occurred at the Facility (i.e., Individual #253, Individual #275, Individual #297, Individual #169, Individual #191, and Individual #172) (i.e., chemical restraints were excluded and only the first restraint in a series of restraints that occurred one after the other were used in this review), there was documentation that a licensed health care professional: ▪ j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in nine (90%) of the instance of restraint. Records that did not contain documentation of this included: Individual #297 on 7/15/13 at 10:08 p.m. ▪ k. Monitored and documented vital signs in six (60%) episodes. Records that did not contain appropriate documentation of this included: Individual #253 on 5/30/13 at 7:54 a.m.; Individual #169 on 6/10/13 at 4:13 p.m.; Individual #191 on 6/26/13 at 6:26 a.m.; and Individual #172 on 6/12/13 at 9:09 a.m. Problematic issues that resulted in noncompliance included 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 five (50%) episodes. Records that did not contain appropriate documentation of this included: Individual #253 on 7/2/13 at 7:41 a.m.; Individual #275 on 7/9/13 at 9:30 a.m.; Individual #297 on 7/15/13 at 10:08 p.m.; Individual #191 on 6/26/13 at 6:26 a.m.; and Individual #172 on 6/12/13 at 9:09 a.m. 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. Based on documentation provided by the Facility, no restraints had occurred off the grounds of the Facility in the last six months. In the future, if restraints are implemented off-grounds, a sample will be reviewed to ascertain if a licensed health care professional: ▪ m. Conducted monitoring within 30 minutes of the individual's return to the Facility in __ out of ___ (__%). ▪ n. Monitored and documented vital signs in ___ (___%). ▪ o. Monitored and documented mental status in ___ (___%).	

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		Sample #C.3 was selected from the list the Facility provided of individuals who had medical restraint in the last six months. It represents 47% of the individuals for whom medical restraint was used. (Sample #C.3 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. ▪ p. In none out of 10 (0%), the physician specified the schedule of monitoring required or specified Facility policy regarding this was followed. ▪ q. In none out of 10 (0%), the physician specified the type of monitoring required if it was different than the Facility policy. ▪ r. In none out of 10 of the medical restraints (0%), appropriate monitoring was completed either as required by the Settlement Agreement, Facility policy, or as the physician prescribed. While a physician's order was available for each of the 10 restraints in the sample, none of the orders contained a schedule of monitoring or type of monitoring. The Restraint Checklist specified the frequency of monitoring for use of a chemical for crisis intervention, but not for use of chemical restraint for a medical purpose. A review of the frequency of monitoring for each of the 10 restraints in the sample revealed no clear pattern of monitoring. Monitoring intervals ranged from every 15 minutes, to 30 minutes to an hour or more. The total time monitored also varied widely. The Monitoring Team noted that these findings had not improved since the last monitoring report, and there was no Action Plan to address this. Based on this review, the Facility was not in substantial compliance, because the curriculum and training for restraint monitors was not adequate in that it did not address how to assure accuracy and consistency in the documentation of restraints and did not have a clear method for measuring the competency of those receiving the training. 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	A sample (Sample #C.1) of 19 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 19 (100%), continuous one-to-one supervision was provided. The entries for LOS on eight restraint checklists indicated "1:2" as the level of supervision. However, upon discussion with the Director of Behavioral Services it was determined that the intention had been to indicate the coverage was two staff for one individual which is commonly expressed as 2:1 (staff to individual.) In the future, care should be taken to express the staff to individual ratio correctly.	Noncompliance

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	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.	▪ b. In 19 (100%), the date and time restraint was begun; ▪ c. In 19 (100%), the location of the restraint; ▪ d. In 14 (74%), 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 were Samples #C1.6, #C1.8, #C1.9, #C1.15, and #C1.17 (as discussed with regard to C.1.g above). ▪ e. In 19 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Section C.8. Each form contained a list of attempts to avoid restraint, but none provided the timeframe in which the attempts occurred or the effectiveness of any of the attempts. ▪ f. In 18 (95%), the specific reasons for the use of the restraint. The one that did not was Sample #C1.16, where the individual's behavior was described as aggressive and harmful, but where no specifics were provided. ▪ g. In 19 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ h. In 19 (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 (only the 14 physical or mechanical restraints were considered), including: o i. In 14 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration); o j. (Not applicable, since none of the 14 restraints lasted 15 minutes.) In (___%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; and o k. (Not applicable, since none of the 14 restraints lasted 15 minutes.) In ___ (___%), the care provided by staff during restraint lasting more than 30 minutes, 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 14 (100%), the level of supervision provided during the restraint episode; ▪ m. In 14 (100%), the date and time the individual was released from restraint; and Based on a review of 10 restraint records for six individuals for restraints that occurred at the Facility (i.e., Individual #253, Individual #275, Individual #297, Individual #169, Individual #191, and Individual #172) (i.e., chemical restraints were excluded and only the first restraint in a series of restraints that occurred one after the other were used in this review): ▪ n. In 10 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented.	

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		▪ o. In a sample of records (Sample #C.1), restraint debriefing forms had been completed for 19 (100%). ▪ p. A sample of 10 individuals subject to medical restraint was reviewed (Sample #C.3), and in none (0%), there was evidence that the monitoring had been completed as required by the physician's order. As indicated with regard to Section C.5, physician's orders did not specify monitoring and the monitoring that did occur did not appear to be following any specific plan or protocol. Sample #C4 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 four (80%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the Behavior Health Specialist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met, though the name of the licensed health care professional did not appear on the form. The one record that did not have the consult form was Sample #C1.15. Based on this review, the Facility was not yet in substantial compliance due to the lack of physicians' orders for the types and schedules of monitoring for medical restraints and while there was progress in documenting the events prior to the behavior that caused restraint, this was an area that required further attention.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation, between 2/1/13 and 7/31/13, a total of 22 individuals were restrained one or more times (i.e., using physical, chemical, and/or mechanical restraint) as part of crisis intervention. Of these, a total of seven individuals were placed in restraint more than three times in any rolling 30-day period. A random sample (Sample #C.6) of three of these individuals (reflecting a sample of 43%) was selected for review to determine if the requirements of the Settlement Agreement were met. It should be noted that the current sample did not include three individuals placed in restraints classified as "protective mechanical" (i.e., Individual #58, Individual #9, and	Noncompliance

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		individual #273) or the 27 individuals who experienced mechanical or chemical restraint related to medical or dental procedures. For each individual selected (as described above), four to five consecutive restraints that occurred within a 30-day rolling period were identified and reviewed. Documentation from these specific incidents were requested and reviewed, including: Crisis Intervention Restraint Checklists, Crisis Intervention Face-to-Face Assessment and Debriefing Forms, Crisis Intervention Restraint Plans, Positive Behavior Support Plans, Individual Support Plans, ISP Addendums, and Monthly Behavioral Services Reviews. It should be noted that the PBSP and Crisis Intervention Restraint Plan (CIRP) in place at the time of the identified restraints were requested for review. However, this documentation was not always provided (e.g., the PBSP for Individual #169 and Individual #275, as well as the CIRP for Individual#275). The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. a. For two individuals (67%), there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. The following are examples of where this did occur: o An Individual Support Plan Addendum, dated 3/19/13, indicated that the IDT for Individual #275 met and discussed the four restraints that occurred on 3/8/13. The ISPA template designed to facilitate adequate team review (following more than three restraints in any rolling 30-day period) appeared to be utilized (specific details are discussed below); o An ISPA, dated 5/2/13, indicated that the IDT for Individual #169 met and discussed the five restraints that occurred on 4/17/13 and 4/29/13. The ISPA template designed to facilitate adequate team reviewed (following more than three restraints in any rolling 30-day period) appeared to be utilized (specific details are discussed below). The following is an example of where the team failed to adequately meet within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days to discuss the specific restraints as identified: o An ISPA, dated 3/28/13, indicated that the IDT for Individual #40 met and discussed the four restraints that occurred on 3/2/13. However, the meeting was held more than three weeks (i.e., in excess of 10 business days) after the restraints were implemented. Although the IDT did not meet in a timely fashion, the team appeared to utilize the ISPA template designed to facilitate adequate team review. b. Of the three individuals reviewed, three (100%) of individuals' teams (as reflected in ISPAs) discussed each individual's adaptive skills as well as biological, medical, and	

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		psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables impacting the individual's behavior. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in three of the cases (100%). Of these, there was evidence of an action plan, discussion, or recommendation, identified in the ISPA, for modifying them to prevent the future probability of restraint in two (67%) of the cases, as discussed above. o It was unclear why the ISPA (dated 3/19/13) for Individual #275 did not include rationale for several of the recommendations outlined in the action plan (i.e., regarding male staffing) and why significant IDT concerns regarding underlying psychiatric issues were not adequately addressed in the current action plan. It should be noted that the IDT action plan did evidence that Individual #275 was referred to CASA Amistad (SASH). However, because the nature of this referral was unclear to the Monitoring Team, its implication(s) with regard to meeting the identified needs of Individual #275 could not be determined. The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should ensure conspicuous evidence of action plans or recommendations for any potentially contributing factors (e.g., adaptive behavior and/or medical, psychiatric, or psychosocial) the IDT identified. In addition, the Facility should encourage IDTs to review data on skill acquisition related to replacement behaviors and/or other adaptive (e.g., coping) responses potentially related to or identified as a replacement for the behaviors that led to restraint.	
	(b) review possibly contributing environmental conditions;	a. For two individuals (67%), there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. Documentation did evidence an ISPA for Individual #40, however, the meeting was held more than three weeks (i.e., in excess of 10 business days) after the restraints were implemented. b. Of the three individuals reviewed, three (100%) of the individuals' teams (as reflected in ISPAs) appeared to discuss potential contributing environmental conditions. c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoked restraints in three of the cases (100%). Of these, there was	Noncompliance

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		evidence of an action plan, discussion, or recommendation, identified in the ISPA, for modifying them to prevent the future probability of restraint in three of the cases (100%). o Although not conspicuous in all of the action plans for the three individuals, documentation did appear to support IDT discussion of the programming currently in place, which appeared to include environmental factors. The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with teams to ensure conspicuous evidence within action plans for any potentially contributing environmental factor the IDT identifies.	
	(c) review or perform structural assessments of the behavior provoking restraints;	a. For two individuals (67%), there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. Documentation did evidence an ISPA for Individual #40, however, the meeting was held more than three weeks (i.e., in excess of 10 business days) after the restraints were implemented. b. For three (100%), there was evidence of discussion of potential environmental antecedents to the behaviors that provoke restraint. It should be noted that the IDT for Individual #40 appeared to discuss potential environmental antecedents to the behaviors that provoked restraint, as noted on the ISPA (dated 3/28/13). However, there was not a Structured Functional Behavior Assessment (SFBA) or comprehensive psychological evaluation yet completed at the time of the restraints. The team noted this and discussed its expected completion (it was completed over three months later on 7/10/13). c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoked restraints in one of the cases (33%). Of these, there was evidence of an action plan, discussion, or recommendation, identified in the ISPA, for modifying them to prevent the future probability of restraint in one of the cases (100%). The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with teams to ensure conspicuous evidence of IDT discussion regarding potential environmental antecedents likely precipitating behaviors that lead to	Noncompliance

#	Provision	Assessment of Status	Compliance
		restraint. Consideration should be given to revising the format of the ISPA to assist IDTs in specifically addressing these factors.	
	(d) review or perform functional assessments of the behavior provoking restraints;	a. For two individuals (67%), there was documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. Documentation did evidence an ISPA for Individual #40, however, the meeting was held more than three weeks (i.e., in excess of 10 business days) after the restraints were implemented. b. For three individuals reviewed, there was evidence of discussion of the variable or variables that potentially are maintaining the behavior provoking restraints. It should be noted that the IDT for Individual #40 appeared to discuss potential maintaining variables of the behaviors that provoked restraint, as noted on the ISPA (dated 3/28/13). However, there was not a SFBA or comprehensive psychological evaluation yet completed at the time of the restraints. The team noted this and discussed its expected completion (it was completed over three months later on 7/10/13). c. Of these individuals, one or more of these factors were hypothesized to affect the behaviors that provoke restraints in one of the cases (33%). Of these, there was evidence of an action plan, discussion, or recommendation, identified in the ISPA, for modifying them to prevent the future probability of restraint in one of the cases (100%). The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure documentation of an ISPA within 10 business days following each episode of an individual having more than three restraints in a rolling 30 days. In addition, the Facility should consider working with teams to ensure conspicuous evidence of IDT discussion and related recommendations regarding potential variable(s) that likely maintain the behaviors that lead to restraint. Consideration should also be given to revising the format of the ISPA to assist IDTs in specifically addressing these factors.	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	a. Of the three individuals reviewed, three (100%) individuals appeared to have a current PBSP implemented at the time of the restraints. However, it should be noted that the PBSP in place at the time of the selected restraints was only provided for one (33%) of the individuals (i.e., Individual #40) as requested by the Monitoring Team. That is, PBSPs implemented at the time of the restraints were not provided as requested for Individual #169 and Individual #275. However, the current PBSPs for Individual #169 and Individual #275, that were developed and implemented after the selected restraints (as described above), were provided and available for review.	Noncompliance

#	Provision	Assessment of Status	Compliance
	be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	As a result, a full review could not be completed of the requirements of metrics b through e for this subsection, and this potentially impacted the Facility's compliance rating. Of the three individuals reviewed, two (67%) individuals appeared to have a current crisis intervention plan (CIP) implemented at the time of the restraints, including Individual #40 and Individual #275. However, it should be noted that the CIP in place at the time of the selected restraints was only provided for one individual (i.e., Individual #40) as requested by the Monitoring Team. The implications of this restricted review should be noted below with regard to metrics f through i for this subsection. b. Zero (0%) had operationally defined target behaviors. More specifically, although physical aggression was defined in the PBSP for Individual #40, property destruction was not. Similar to physical aggression, property destruction was identified (on two of the four Restraint Checklists) as one of the reasons for restraint (i.e., behavior causing imminent danger to self or others), c. Zero (0%) contained functional replacement behaviors. More specifically, although a replacement behavior was identified and defined for Individual #40, the IDT stated that the lack of an SFBA questioned the underlying function of the behavior that led to restraint. d. One (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint (i.e., Individual #40). e. Zero (0%) contained interventions to weaken or reduce the behaviors that provoked restraint that are clear, precise and based on a functional assessment. More specifically, although strategies to weaken or reduce behaviors leading to restraint were prescribed for Individual #40, they did not appear to be acceptable to the IDT (i.e., based on a functional assessment). f. One (100%) CIP delineated the type of restraint authorized (i.e., Individual #40). g. One (100%) CIP specified the maximum duration of restraint authorized. h. One (100%) specified the designated approved restraint situation. i. One (100%) specified the criteria for terminating the use of the restraint.	

#	Provision	Assessment of Status	Compliance
		The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that behaviors that appear to be consistently placing individuals at risk of imminent harm be considered for and/or identified in behavioral programming.	
	(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	a. Of the three individuals reviewed, zero (0%) provided evidence of the collection of treatment integrity data (i.e., based on review of the available monthly notes). b. Of the three individuals reviewed, zero (0%) provided evidence that their PBSPs were implemented with at least 80% treatment integrity. The Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure the adequate completion of integrity checks, with estimates above 80%, and ongoing documentation and monitoring (e.g., inclusion in monthly PBSP notes).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	a. Of the three individuals reviewed, three (100%) individuals' teams (as reflected in ISPAs) appeared to review and discuss the current PBSP. However, as discussed below, this review for Individual #40 was not sufficient. b. Of the three individuals reviewed, the ISPA indicated that a revision was necessary in none (0%) of the cases. However, as noted above with regard to Section C.7.e, property destruction was identified on two of the four Restraint Checklists as one of the reasons for restraint (i.e., behavior causing imminent danger to self or others), but not identified or defined as a target behavior in the PBSP of Individual #40. As a result, the one BSP that should have been revised was not (0%). The Facility remained out of compliance with this provision.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The Facility process for review of a restraint required the Restraint Monitor to review the restraint checklist and document the review on the Face-to-Face form. The Behavior Health Specialist reviewed both forms in conjunction with completing the debriefing sheet. Within three business days of the restraint, the Unit Team was to review the restraint record, 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 more than 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. This process	Noncompliance

#	Provision	Assessment of Status	Compliance
		was essentially the same as during the Monitoring Team's last review. One difference noted from the last visit was that the Restraint Reduction Committee was not attended by a majority of the members. While this did not prevent a review by the behavior specialists and others who did attend, the composition of the team should be reconsidered and policy adjusted, if the membership is expected to be different than currently specified in policy. A sample of documentation related to five incidents of crisis intervention restraint was reviewed, including Samples #C1.7, #C1.9, #C1.11, #C1.14, and #C1.15. The documents reviewed, included the Unit Team meeting minutes, the IMRT meeting minutes, the Restraint Reduction Committee minutes, any ISP addenda, and the debriefing form. This documentation showed that: ▪ a. In three (60%), the review by the Unit IDT occurred within three business days of the restraint episode and was documented by the name entered into the electronic form rather than by the signature on the Restraint Checklist. The cases where this did not occur were Sample #C.1.9 and #C1.15. While the Unit IDT minutes for each of these restraints had documented a review in a minimal manner (as discussed in "d" below), the dates recorded on the Restraint Checklists were different than the dates of the meetings. For example, in Sample #C1.9 the Unit IDT date was 7/16/13 (one day after the restraint.) However, the restraint checklist recorded the date of that meeting as 7/19/13 (four days after the restraint.) Likewise, in Sample #C.1.15 the Unit IDT minutes were dated 7/8/13, while the date recorded on the restraint checklist was 7/19/13. ▪ b. In two (40%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by electronic signature on the Restraint Checklist. As with the dates for Unit IDT reviews, the IMRT review dates were not the same as those recorded in the restraint checklists. The three that were not dated as reviewed within three business days were Samples #C1.9, #C1.11, and #C1.15. ▪ c. In two (40%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. In the three records all of which included Face-to-Face and Debriefing forms, there was missing or inconsistent information which would have made a full review of the restraint difficult or which should have been noted in the review. o Sample #C1.9: there were inconsistencies in the Face-to-Face documentation as noted in C.5.g above with regard to the application of restraint; o Sample #C1.11: there were inconsistencies in the Face-to-Face (noted in	

#	Provision	Assessment of Status	Compliance
		C.5.f and .g above) with regard to both application and consequences of restraint; o Sample #C1.15: there was not a description of events prior to the behavior that caused the restraint and neither the Face-to-Face nor the Debriefing remedied this (as discussed in C6.d above). ▪ d. In none (0%), the review conducted by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. None of these five records contained minutes of Unit IDT or IMRT meetings that provided the information needed to establish the criteria listed. There were no records of discussions or decisions of any kind. Most comments were "missing data." ▪ e. In none (0%), referrals were made to the IDT, as appropriate. ▪ f. Since no referrals to IDTs were made, this metric was not applicable. Of the ___ referred to the team, ____ appropriate changes were made to the individuals' ISPs and/or PBSPs. Based on this review the Facility remained out of compliance with this provision due to lack of documentation of review which should have been included in the minutes of the Unit IDT and IMRT meetings and a consistent recording of the dates of the Unit IDT and IMRT reviews on the Restraint Checklists. Observation of a Unit IDT and an IMRT meeting during the onsite visit revealed discussion, problem solving amongst members and directions about follow-up activities. If this kind of discussion was the norm, it was difficult to understand why the minutes did not document those discussions and directions.	

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 9/13/13; o CCSSLC Action Plans, updated 9/13/13; o Presentation Book for Section D; o Abuse/Neglect/Exploitation (A/N/E) Investigations between 2/1/13 and 7/31/13, undated; o CCSSLC Abuse Neglect and Exploitation – Monthly Trending Report, from 3/1/13 to 7/31/13; o Investigations Conducted Solely by Facility between 2/1/13 and 7/31/13; o CCSSLC Unusual Incidents – Monthly Trending Report, from 3/1/13 to 7/31/13; o CCSSLC Staff Status Tracking – by Date, dated 8/23/13; o List of eight individuals who are currently on the chronic caller list, dated 6/3/13 (the individuals on this list had been reviewed as late as 9/5/13, suggesting the date of the list had not been changed after the reviews occurred); o Course Delinquency List for ABU0100, Abuse and Neglect, dated 9/28/13; o Course Delinquency List for UNU0100, Unusual Incidents, dated 9/28/13; o Adult Protective Services (APS) Training Transcript Crosswalk – Corpus Christi, undated; o CCSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 9/6/13 (fingerprint background check due 10/28/13); o List of CCSSLC Volunteers with corresponding date on which background check was completed, dated 10/12/13 (with new volunteers having more recent dates); o Atlantic Unit Management Review Team Meeting Minutes for 10/1/13; o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) reports of 4/10/13, 7/29/13, and 8/15/13; o **Sample #D.1**: included a sample of DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports:

Sample ID #	UIR #	DFPS #	Type	Outcome
D1.1	363	42765973	Neglect	Confirmed
D1.2	353	42760133	Verbal	Unconfirmed
D1.3	339	42751240	Physical II	Unfounded
D1.4	324	42744661	Physical II	Unfounded
D1.5	315	42739650	Physical	Unconfirmed
D1.6	304	42727863	Physical II	Unconfirmed
D1.7	293	42712541	Verbal	Unconfirmed
D1.8	281	42703309	Physical	Unconfirmed

D1.9	271	42693924	Physical	Unfounded
D1.10	260	42683564	Referral	N/A
D1.11	379	42778654	Physical	Pending
D1.12	367	42767747	Verbal	Inconclusive
D1.13	390	42785926	Verbal	Unconfirmed
D1.14	398	42792832	Physical	Confirmed
D1.15	437	42813546	Verbal/physical	Inconclusive
D1.16	425	42809797	Verbal	Unconfirmed
D1.17	414	42804993	Physical	Unconfirmed
D1.18	392	42786200	Neglect/physical	Unconfirmed
D1.19	389	42785242	Neglect/physical	Unconfirmed
D1.20	403	42797755	Referral	N/A

- **Sample #D.2**: included a sample of six (20%) of the 27 Facility-only investigation reports listed on the document: Investigations Conducted Solely by the Facility, completed between 2/1/13 and 7/31/13:

Sample ID #	UIR #	Type
D2.1	253	Serious injury
D2.2	328	Serious injury
D2.3	349	Ingestion of object
D2.4	358	Unauthorized departure (UD) - off campus
D2.5	400	Serious injury
D2.6	448	Encounter with law enforcement

- **Sample #D.3:** None selected
- **Sample #D.4:** the sample of 12 Individual Support Plans (ISPs) reviewed included: Individual #97, Individual #353, Individual #13, Individual #46, Individual #61, Individual #269, Individual #183, Individual #9, Individual #290, Individual # 367, Individual #16, and Individual #326;
- **Sample #D.5:** a subsample of the investigations included in Samples #D.1 and #D.2. This included investigation reports in which programmatic recommendations were made and/or the IMRT made recommendations. Included in the sample were Samples #D.1.15, #D1.18, #D1.19, #D2.1, and #D2.2;
- **Sample #D.6:** a sample of 10 to 20 completed Record Audits to determine whether significant injuries had been reported. None were reviewed on this visit since the Incident Management Coordinator (IMC) indicated changes were being made to the process; and
- **Sample #D.7:** No action plans, developed as a result of trend analysis, were available for this section.

- **Interviews with**:
  - Mark Cazalas, Facility Director;

	○ Brandon Riggins, Assistant Director of Programs; ○ Jon Breseman, Incident Management Coordinator; ○ Cynthia Velasquez, Director for Quality Assurance; ○ Beverly Okin-Larkin, System Analyst; ○ Elena Martinez, Program Compliance Monitor for Section D; ○ John Henley, Unit Director for Atlantic; ○ Cheryl Huff, John Cortez, and Javier Luna, CCSSLC investigators; ○ Staff members from various residential locations; and ○ Individuals in various residential locations. ▪ **Observations of**: ○ QA/QI Council Meeting, on 10/3/13; ○ Atlantic Unit Team Meeting, on 10/1/13; ○ Incident Management Team (IMT) meeting, on 10/1/13; and ○ Residences: #522A, #522B, #522C, #522D, #524A, #524B, #524C and #524D.
	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 the same 18 of the 22. The Facility submitted a Self-Assessment for Section D, dated 9/13/13. 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 D, 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, as well as interviews with staff: ○ The monitoring/audit tools the Facility used to conduct its self-assessment consisted of a template entitled: "The Settlement Agreement Cross-Referenced with ICF-MR Standards: Section D – Protection from Harm – Abuse, Neglect and Incident Management." In conducting its self-assessment, the Facility selected a sample of investigations from the database of all cases from the previous two months, and applied this tool. ○ These monitoring/audit tools included many of the necessary indicators to allow the Facility to determine compliance with the Settlement Agreement. The language in the monitoring tool was consistent with the provisions of the Settlement Agreement. However, as discussed in further detail below, some of the indicators/metrics necessary to determine compliance with all provisions of the Settlement Agreement were missing. The Facility should review the Monitoring Team's report to identify additional indicators that should be assessed as part of the Facility's Self-Assessment. ○ The monitoring tools included some adequate methodologies. For example, the investigation case files, training documentation, and rights posters were reviewed. Interviews and observation were to be conducted as appropriate. However, "appropriate"

	was not clearly defined, and there was no detailed evidence provided of observation in living units or interviews with individuals or staff. The monitoring appeared to consist of documentation review alone. o The Self-Assessment identified the sample(s) sizes, including the number of records reviewed in comparison with the number of records in the overall population (i.e., n/N for percent sample size). Sample sizes had improved since the Monitoring Team's last visit and were adequate to assess compliance with the provisions of the Settlement Agreement. o The monitoring/audit tools had instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: The Program Compliance Monitors from the Quality Assurance Department worked collaboratively with Department staff to conduct the audits. (Department staff positions were not identified in the documentation reviewed.) o It could not be determined from the information provided whether the staff persons responsible for conducting the audits were competent in the use of the tools, and whether they were clinically/programmatically competent in the relevant area(s). o Inter-rater agreement could not be established because the results from the monitoring the Incident Management Coordinator completed were not being loaded into the electronic database. This delay in entry was the result of a large increase in allegations during the summer of 2013, and was being resolved while the Monitoring Team was on site. ▪ The Facility used some relevant data sources. In addition to data from the audits of investigation files, the Facility also cited some other data in its Self-Assessment. For example, it used data from the Competency and Training Department database on A/N/E training. However, the Facility did not present data on key indicators or outcome measures in its Self-Assessment. It was the Monitoring Team's understanding that State Office and the Facility were working on developing such measures. ▪ The Facility consistently presented some data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Many of the findings were presented as specific, measurable indicators. However, some indicators were missing. Just as one example, Section D.3.e includes a number of requirements related to investigation reports. The Facility addressed three, but did not address recommendations for corrective action, which is an important element of D.e.3. 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 data did not identify in sufficient detail the areas in need of improvement. There was scant analysis of the information, without identifying, for example, potential causes for the issues or connecting the findings to 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: During this review, the Monitoring Team found the Facility to be in compliance with 18 out of 22 provisions of Section D, which was the same number of provisions that were

	in compliance during the last review. Progress was noted in a number of areas. Highlights of progress included: ▪ UIRs had been improved through the use of new Adobe software to allow more flexibility in moving information from the DFPS report to the associated UIR and through reducing unnecessary duplication between the two reports. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to: • Solve the problem of completing UIRs on time and when a report could not be done on time, requesting an extension. • Establish the processes for auditing injuries and completing investigations of trends of injuries or trends of peer-to-peer injuries, or patterns of injuries discovered either through the audit process or through the monthly reviews of trend data. • Load the QA monitoring data into the system so that it can be compared with the IMC unit data to establish a healthy check on performance. • Include the history of alleged perpetrators in the UIR or include the list in the record. • Assure that documentation of the review of investigations includes comments and directions for follow-up when necessary, and that the follow-up is tracked to conclusion.

#	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	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	Substantial Compliance

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

According to data the Facility provided in a document entitled: Data Charts – Incidents, the numbers of abuse/neglect/exploitation allegations for the past two six-month periods were:

<table>
<tr><th></th><th>9/1/12 to 2/28/13</th><th>3/1/13 to 8/31/13</th></tr>
<tr><td>Total abuse allegations</td><td>333</td><td>336</td></tr>
<tr><td>Physical</td><td>181</td><td>196</td></tr>
<tr><td>Sexual</td><td>53</td><td>20</td></tr>
<tr><td>Verbal/Emotional</td><td>99</td><td>120</td></tr>
<tr><td>Abuse substantiated</td><td>30</td><td>16</td></tr>
<tr><td>Physical</td><td>22</td><td>14</td></tr>
<tr><td>Sexual</td><td>0</td><td>0</td></tr>
<tr><td>Verbal/Emotional</td><td>8</td><td>2</td></tr>
<tr><td>Abuse inconclusive</td><td>41</td><td>19</td></tr>
<tr><td>Physical</td><td>29</td><td>13</td></tr>
<tr><td>Sexual</td><td>1</td><td>1</td></tr>
<tr><td>Verbal/Emotional</td><td>11</td><td>5</td></tr>
<tr><td>Total neglect allegations</td><td>170</td><td>146</td></tr>
<tr><td>Neglect substantiated</td><td>44</td><td>20</td></tr>
<tr><td>Neglect inconclusive</td><td>26</td><td>12</td></tr>
<tr><td>Total exploitation allegations</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation substantiated</td><td>0</td><td>0</td></tr>
<tr><td>Exploitation inconclusive</td><td>0</td><td>0</td></tr>
</table>

* Note: this chart does not include all types of findings and thus the list of findings will not total to the total A/N/E allegations.

According to Facility data provided in response to on an on-site request, the numbers of</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		Unusual Incidents investigated over the past two six-month periods included:	

	9/1/12 to 2/28/13	3/1/13 to 8/31/13
Deaths	5	2
Serious Injuries	6	14
Sexual Incidents	3	1
Suicide Threat (credible)	1	1
Unauthorized Departure	3	3
Choking	5	0
Other	2	7
Total	25	28

Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

Metric 2.a.2: According to CCSSLC Policy D: Protection from Harm – ANE Policy, and D.2 Reporting Abuse, Neglect, Exploitation, staff were required to report abuse, neglect, and exploitation immediately or at least within one hour by phone to the Director and to the DFPS number. This was consistent with the Settlement Agreement requirements.

Metric 2.a.3: With regard to unusual/serious incidents, the Facility policy entitled CCSSLC Policy D – Serious Event Notification required staff to report unusual/serious incidents within one hour from the time of discovery. The process for staff to report such incidents required staff to call the Director or designee. This policy was consistent with the Settlement Agreement requirements.

Metric 2.a.4: Although this was not a measure used to determine compliance, based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

Metric 2.a.5: Although this was not a measure used to determine compliance, based on responses to questions about reporting, 10 of 10 (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents.

Based on a review of the 20 investigation reports included in Sample #D.1:

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		▪ Metric 2.a.6: 19 (95%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy or the time of the event was unknown, based on the circumstances of the allegations in conjunction with the investigation report, there was not an expectation of reporting because there was not a confirmation or reasonable cause to believe that abuse, neglect, and exploitation occurred. In the one that did not: o Sample #D1.1 involved a staff member driving a vehicle with individuals on board. Another staff member noticed the driver texting while driving and using the phone, but did not report it for three days. Neglect was confirmed and the driver was terminated. However, there were no recommendations to discipline or retrain the staff member who did not report timely and who did not take action to protect the individuals in the vehicle. ▪ Metric 2.a.7: Twenty (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.8: For the one allegation for which staff did not follow the Incident Management (IM) Policy and Reporting Matrix reporting procedures, Sample #D1.1, the none of the one UIR/investigation folder (0%) included recommendations for corrective actions. Based on a review of six investigation reports included in Sample #D.2: ▪ Metric 2.a.9: Six (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy or the individual was self-reporting ingestion of a foreign object or the time of the incident was unknown. ▪ Metric 2.a.10: Six (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. ▪ Metric 2.a.11: There were no incidents in this sample where the staff did not follow policy. Had there been, the following metric would have been evaluated: "For the __ unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, ___ UIRs/investigation folders (__%) included recommendations for corrective actions." Metric 2.a.12: The Facility had a standardized reporting format. Metric 2.a.13: Based on a review of 26 investigation reports included in Samples #D.1 and #D.2, 26 (100%) contained a copy of the report using the required standardized format and were completed fully.	

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		The Facility remained in substantial compliance with this provision. Although DFPS and the Facility had not appropriately addressed the failure of a staff member to timely report an allegation of neglect, this involved one incident in the sample. Given that the Facility had reacted appropriately to other staff members' failure to report alleged abuse/neglect (i.e., as discussed in further detail with regard to Section D.2.d), this appeared to be an isolated incident. However, in order to maintain substantial compliance in the next round of monitoring, the Facility will need to assure that any deviation from the timeframes for reporting are fully explained in the reports, and that proper disciplinary procedures and/or retraining are taken to address any failure to report timely.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to CCSSLC Policy 7.2, staff identified as alleged perpetrators would be placed on Temporary Work Reassignment (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. Based on a review of 26 investigation reports included in Sample D.1 and Sample D.2, 15 of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Of the remaining, three were streamlined investigations (Samples #D1.3, #D1.4 and #D1.9). Two involved unknown alleged perpetrators (Samples #D1.2, and #D1.10), and six involved unusual events, not suspected to be possible abuse, where the Facility investigated (Sample #D2.1 to #D2.6.). As a result all 26 (100%) were addressed appropriately. Based on a review of 15 investigation files included in Sample #D.1 and Sample #D.2, where staff had been removed, a total of 14 (93%) showed that staff were reinstated only at the conclusion of the investigation. In one, (Sample #D1.15), the determination was inconclusive and it was not clear from the status tracking sheet whether the staff member had been returned to work. Based on a review of 26 of the above documents, it was documented that adequate additional action was taken to protect individuals in 26 cases (100%). Based on this review, the Facility remained in substantial compliance.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and	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 consistent with the requirements of the Settlement Agreement, as was the curricula. Review of 24 staff records (Sample #C.2), showed that 24 (100%) of these staff had	Substantial Compliance

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	exploitation, and maintaining documentation indicating completion of such training.	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, CCSSLC Course Delinquency List for abuse (ABU0100) and unusual incidents (UNU0100), generated on 9/28/13, showed that 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 Facility's performance on this provision, the Facility remained in 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 personnel action in response to any mandatory reporter's failure to report abuse or neglect.	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. 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 two staff. Personnel actions related to these failures were reviewed, which revealed the following: ▪ Both staff had been terminated from employment. ▪ However, as noted in Section D.3.e below, there was one person in Sample #D1.1 who did not make prompt notification of possible abuse/neglect, but did not appear on the list of staff identified. This provision remained in substantial compliance. However, to sustain substantial compliance with this provision, the Facility needs to be vigilant in identifying failure to report abuse and neglect and to take appropriate action when such failure is identified.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	According to Section D.19 of the Facility policy manual, Qualified Intellectual Disability Professionals (QIDPs) 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 QIDP was to	Substantial Compliance

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	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.	describe the process to the individual at the meeting. The ISP Meeting Guide also contained instructions to the QIDP to present the A/N/E guide during the annual meeting and to document that action. 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 were discussed. The guide was found to be adequate. Based on a review of 12 individuals' ISPs (Sample #D.4), 11 individuals (92%), 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 and this was documented on their ISP. For Individual #9, no documentation of discussion or distribution of the A/N/E guide was found. In interviewing a sample of 10 individuals, 10 were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. No serious incidents were listed as having been reported by an individual or his LAR. However, Samples #D1 and #D2 both contained examples of reporting that was made by individuals. For example: Sample #D2.4 involved ingestion of a foreign object that was reported to staff by the individual and then reported by staff to the Director and the nurse. Sample #D1.4 made clear in the reports of witness testimony that the individual had reported name-calling. There was no evidence that staff had tried to interfere with the individual's report. The Facility remained in substantial compliance with this provision.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According Section D.20 of Facility policy and procedure manual, all residences and day programs were to have the "Rights Poster" on display. A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. The Monitoring Team's observations of eight living units on campus showed that all (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There were additional posters displayed in residences and office buildings alerting individuals and LARs to the availability of the human rights officer and ombudsman for assistance with exercising individual rights.	Substantial Compliance

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		As a result, the Facility remained in substantial compliance with this provision.	
	(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 20 allegation investigations completed by DFPS (Sample #D.1), in 16 for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in 16 (100%). Based on a review of six investigations completed by the Facility (Sample #D.2), none required referral to law enforcement. The Facility remained in substantial compliance in this provision.	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 an appropriate or timely manner.	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. Based on interviews with 10 staff, 10 (100%) reported they were confident that retaliation would not be tolerated. Based on interviews with 10 individuals served by the Facility, 10 (100%) reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there was one concern noted related to potential retaliation. In Sample #D1.15, a staff member indicated that she had not reported an incident of potential abuse. When presented with possible disciplinary action, she indicated she had not reported because she feared retaliation from the alleged perpetrator. Personnel action was taken for failure to report and the staff member was terminated. Staff were retrained on reporting and on	Substantial Compliance

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		retaliation to guard against further failures to report. However, it was not clear that staff at the location had been interviewed to determine if they, too, feared retaliation and if a source for that fear could be identified and addressed. 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 had in good faith had reported an allegation of abuse/neglect/exploitation. None were reported. Based on the lack of reports of retaliation and on the Facility's handling of the discovery of a witness who admitted failure to report based on fear of retaliation, the Facility remained in substantial compliance with this provision. However, the Facility is encouraged to regularly inquire with staff about potential fear of retaliation, and, when allegations are made of retaliation, increase these efforts. This is particularly important given the Facility's fairly recent history of staff not reporting allegations of abuse.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	A copy of the "State Supported Living Procedure: Injury Audits" dated March 2013 and the associated record review form were provided. On interview, it was learned that these documents were currently undergoing revision. While the forms had been used to conduct injury audits, the results were not available. One challenge had been to make the necessary electronic data files accessible to the Campus Administrators who were scheduled to conduct the audits. Metric 2.i.1: The Facility policy and/or procedures did not define sufficient procedures to audit whether significant injuries are reported for investigation, such as who would conduct the reviews and what reports would be completed, based on the data. Metric 2.i.2: The Facility had not conducted audits at least semi-annually, during the preceding 13 months. The following metrics were not reviewed since audit samples were not available, but will be reviewed during the next monitoring visit. ▪ Metric 2.i.3: The audits conducted **were/were not** sufficient to determine whether significant resident injuries had been reported for investigation. ▪ Metric 2.i.4: ___ of ___ (%) significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate. The Facility was not in compliance with this provision because the procedures were incomplete and audits were not available for review. The Facility found the same in the Facility Self-Assessment. An Action Plan was provided that indicated audits were in process, but the Action Plan needed to indicate when procedures would be updated and in place, to specify the staff who would conduct the audits and to include modifications to	Noncompliance

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		the electronic data system to allow access to staff responsible for the audits.	
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.	Section DD.1 of the CCSSLC Policy and Procedure Manual: ▪ Described in a comprehensive fashion the conduct of investigations; ▪ Required that investigators be qualified by successfully completing: o Comprehensive Investigator Training (CIT0100); o Conducting Serious Investigations or Fundamentals of Investigation training (INV0100); and o Root Cause Analysis. ▪ Required that investigators have training in working with people with developmental disabilities, including persons with mental retardation (MR)/intellectual disabilities (ID), through the completion of People with MR (MEN030); and ▪ Required that investigators be outside of 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. The training records for these investigators were reviewed with the following results: ▪ Six out of six DFPS investigators (100%) had completed the requirements for investigations training. ▪ Six out of six DFPS investigators (100%) had completed the requirements for training regarding individuals with intellectual and developmental disabilities. ▪ Nine out of nine Facility investigators (100%) had completed the requirements for investigations training ▪ Nine out of nine Facility investigators (100%) had completed the requirements for training regarding individuals with intellectual and developmental disabilities.	Substantial Compliance

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		Since all investigators had received the required training, the Facility remained in substantial compliance with this provision.	
	(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. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. ▪ Review of the investigation files in Sample #D1 showed that in 20 out of 20 investigations (100%), Facility staff cooperated with DFPS investigators. ▪ Review of the investigation files in Sample #D2 showed that in six out of six Facility investigations (100%), Facility staff and DFPS investigators cooperated as needed. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding (MOU), dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General (OIG). 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 20 investigation records from DFPS (Sample #D.1), 16 had been referred to law enforcement agencies. For 16 out of these (100%), there was adequate coordination to ensure that there was no interference with law enforcement's investigations. DFPS had not concluded one investigation, Sample #D1.11, pending receipt of final instructions from the law enforcement agency that had untaken a criminal investigation. The incident had been reported on 6/15/13. ▪ Of the six investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies.	Substantial Compliance

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		The Facility remained in substantial compliance with this provision.	
	(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 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 20 out of 20 (100%) DFPS investigations; and ▪ Evidence that needed to be safeguarded was in six out of six (100%) Facility investigations. The Facility remained in substantial compliance with this provision.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for	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.	Noncompliance

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	corrective action.	DFPS Investigations The following summarizes the results of the review of DFPS investigations. Note that the total is 19, because the one investigation was still pending (i.e., Sample #D1.11) and was not available for review. ▪ 19 out of 19 (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. ▪ 16 out of 19 (84%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The three that were not were Samples #D1.1, #D1.5 and #D1.18. ▪ For the three that were not completed within 10 days, two (67%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. The one that did not was Sample #D1.5, which was only one day late. ▪ 19 (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 six of the investigations reviewed, recommendations for corrective action were included. In the remaining 13, recommendations were not needed. As a result, in 18 of the 19 investigations (95%), the recommendations were adequate to address the findings of the investigation. The one that was not adequate was Sample #D1.1. It involved a staff member driving a van with individuals on board and using her hand-held phone to call and text, and as a global positioning system (GPS) device. The DFPS report confirmed neglect, and recommended in-service training for staff on using the phone while driving. However, no recommendation was made about the actions of the staff member sitting next to the driver in the front seat who should have insisted the driver stop using the phone and should have insisted on holding the GPS device in an effort to protect the individuals in the vehicle. Nor was there a recommendation concerning the failure of staff members in the car to report the possible neglect for two days. Facility-Only Investigations The following summarizes the results of the review of Facility investigations: ▪ Six out of six (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	

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		well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident. ▪ One out of six (17%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. The one was Sample #D2.4. ▪ 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 Director, and there was documentation of the extraordinary circumstances that necessitated the extension. ▪ Six (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 three of the six investigations reviewed, recommendations for corrective action were included, and in three, there were no recommendations and none were needed. In five of the six investigations (83%), the recommendations were adequate to address the findings of the investigation. The one that was not adequate was Sample #D2.2. The investigation revealed that staff had taken the individual in a wheelchair into the bathroom to be changed, and assisted him out of the wheelchair to stand between two sinks, in violation of his PNMP, which required his helmet to be in place while standing. While he was standing, staff attempted to put on his helmet and he resisted. The individual slid between the sinks and moved side-to-side, hitting his head and causing a laceration. The investigator recommended that the staff member be in-serviced on the PNMP for the individual. Breach of a PNMP can have serious repercussions as it did in this case. At a minimum, there should have been a recommendation for a disciplinary letter in the file of the staff member responsible. Based on the late completion of Facility investigations and lack of filing for extensions, as well as the need for stronger recommendations when staff failed to report or stop abuse and when PMNPs were not followed, the Facility was not in substantial compliance with this provision. The Facility's finding in its Self-Assessment was the same.	
	(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	Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. Metric 3.f.2: The Facility policy and procedures (CCSSLC Policy #002.2 and the related procedure at DD.11 of the CCSSLC Policy and Procedure Manual) were consistent with the DADS policy with regard to the content of the investigation reports.	Substantial Compliance

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	serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations. Note that the number does not match the Sample #D1 of 20, because one DFPS report had not been completed due to law enforcement involvement (i.e., Sample #D1.11). ▪ Metric 3.f.3: In 19 out of 19 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 Metric 3.f.4: In 19 (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.5: In 19 (100%), the name(s) of all witnesses; o Metric 3.f.6: In 19 (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.7: In 19 (100%), the names of all persons interviewed during the investigation; o Metric 3.f.8: In 19 (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 Metric 3.f.9: In 19 (100%), all documents reviewed during the investigation; o Metric 3.f.10: In 19 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. ▪ In all related UIRs, prior reports concerning the alleged victims were listed; ▪ None of the UIRs listed the alleged perpetrators' prior history. Upon inquiry, it was learned that the Facility had changed software for the UIRs. Where the previous software prompted inclusion of the alleged perpetrator history, the new software did not, and as a result, the histories were not routinely included. ▪ DFPS routinely commented on the histories, usually that they were not relevant to the current investigation. (They were able to view the prior history information on their computer screens.) ▪ No conflicting information was found between DFPS reports and UIRs with regard to relevancy of the histories. ▪ It appeared that both the Facility and DFPS were reviewing histories, but that most were not relevant to the cases under investigation. Comments were noted in Samples #D1.4, #D1.9 and #D1.13, where the history of prior unfounded allegations	

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		was used to help establish a pattern of unfounded reports. o Metric 3.f.11: In 19 (100%), the investigator's findings; and o Metric 3.f.12: In 19 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Metric 3.f.13: In six out of six 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 Metric 3.f.14: In six (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.15: In six (100%), the name(s) of all witnesses; o Metric 3.f.16: In six (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In six (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In six (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 Metric 3.f.19: In six (100%), all documents reviewed during the investigation; o Metric 3.f.20: In six (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency: ▪ Prior reports related to the alleged victim were included in the reports (four reports) or a notation was entered that there were no prior reports (two reports.) ▪ No entries of prior reports were made for alleged perpetrators for the reasons listed above in metric #3.f.10. ▪ In two cases where individuals had repeatedly ingested inedible objects, the reports noted the pattern and made recommendations to address the issues (i.e., Sample #D2.1 and #D1.5.) o Metric 3.f.21: In six (100%), the investigator's findings; and o Metric 3.f.22: In six (100%), the investigator's reasons for his/her conclusions. Based on the metrics this section remained in substantial compliance, although the prior	

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		histories of alleged perpetrators had not been included in the UIRs. This appeared on interview to be related to software issues and did not mean that those prior histories were not reviewed and considered. For at least the past three reviews, CCSSLC had provided this information. This appeared to be a temporary failure to comply during an otherwise period of sustained compliance. In future reviews it will be important to see documented evidence of the prior cases involving alleged perpetrators that have been considered. In order to maintain compliance, in future reviews the UIR must list the prior histories of both the alleged victim(s) and the alleged perpetrator(s), or the record, submitted for review, must contain such a list.	
	(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.	Metric 3.g.1: The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete, and coherent. Metric 3.g.2: The Facility policy did require that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Metric 3.g.3: The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f with the exception that: o In one DFPS report (Sample #D1.1), the recommendations were not adequate (as discussed with regard to Section D.3.e above) out of six reports with recommendations. However, that was one of a total of 19 reports or 5% that did not have an adequate recommendation. ▪ Metric 3.g.4: Of 17 reports (20 in sample #D1 less two Administrative Referrals and one pending report), 14 (82%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation. This was determined by comparing the date of completion of the DFPS report to the date on the Review Authority Team sheet. Those that were not were Sample #D1.13, #D1.14, and #D1.15. ▪ Metric 3.g.5: The Facility Director/Incident Management Coordinator did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. Only one of over 200 investigations was returned to DFPS for a methodological review, according to the list provided by the Facility. ▪ Metric 3.g.6: For one of the DFPS investigation files, the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. (Sample #D1.1.) Based on a review of the Facility's data, the Facility did not note the problem with Sample	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		#D1.1. ▪ Metric 3.g.7: In the one investigation report the Facility returned to DFPS for reconsideration (DFPS investigation #42691461 which was not part of the sample), for one (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Metric 3.g.8: Five of six (83%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. The one that was not was sample #D2.6. ▪ Metric 3.g.9: In six out of six investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ Metric 3.g.10: For four the supervisor had identified concerns. For these four investigations (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ Metric 3.g.11: For the one investigations noted above for which the Monitoring Team identified deficiencies (D2.2) the supervisory review did not appear to address these deficiencies. The Facility was in substantial compliance with this provision during the last review in April 2013. However, new metrics had been added to this provision since that time. The result was that for two investigations, the supervisory processes did not discover the issues the Monitoring Team found with those two reports. In addition, issues were identified with completing reviews of DFPS reports within five working days. Because the method of measuring this provision had changed and because the issues identified involved only two reports out of a total of 25 (DFPS and Facility-Only combined), the Facility remained in substantial compliance. However, as agreed upon by the parties, when changes in measurement occur, a mandatory recommendation is made, and similar findings on future reports will result in noncompliance. Specifically, the Facility must timely review DFPS reports, and return them to DFPS when any quality issues are noted. The Facility must also timely review its own investigations.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Metric 3.h.1: The Facility-only investigations did meet the requirements outlined in Section D.3.f. As noted with regard to Section D.3.f, in order to maintain compliance, in future reviews the UIR must list the prior histories of both the alleged victim(s) and the alleged perpetrator(s), or the record, submitted for review, must contain such a list.	Substantial Compliance

#	Provision	Assessment of Status	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.	Metric D.3.i.1: The Facility policy and procedures did require disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric D.3.i.2: In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes. Specifically, 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. Metric D.3.i.3: For three out of five of the investigations reviewed in which disciplinary action was warranted (60%), prompt and adequate disciplinary action had been taken and documented. The two cases where disciplinary action was warranted, but not taken were: ▪ Sample #D1.1: A staff member was terminated for using her cell phone to send text messages while driving individuals on a community outing. However, the staff member sitting next to her in the vehicle did not stop the potentially neglectful behavior and did not report it promptly. No disciplinary action was taken with regard to the staff member who failed to stop the abuse and to report it promptly. ▪ Sample #D2.2: A staff member did not follow the individual's PNMP resulting in a fall and serious injury. It was not clear from the UIR that the staff member had been in-serviced on the PNMP prior to the fall and injury. The staff member was in-serviced after the investigation, but was not disciplined. Breach of a PNMP is a serious matter. Assuming the staff member had been previously in-serviced and failed to follow the plan, some disciplinary action was warranted. If the staff had not been in-serviced before working with the individual, disciplinary action against whoever failed to assure the in-service training occurred would have been appropriate. The three cases where disciplinary action was taken promptly were: ▪ Sample #D1.14: A staff was terminated upon confirmation of abuse. ▪ Sample #D1.15 and #D1.18: Staff members were terminated for failure to report suspected abuse. Based on a review of a subsample of investigations for which recommendations for programmatic action were made (Sample #D5 in the documents reviewed list), the following was found:	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Metric D.3.i.4: For five out of five of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. Recommendations went directly to the Review Authority Team, where they were accepted or rejected and where directions with timeframes were given to address those recommendations. ▪ Metric D.3.i.5: For none out of five investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic action, or when the outcome was not achieved, the plan was modified. No minutes of IMRT meetings were provided to demonstrate how the tracking system was being used to assure recommendations that were carried out achieved the desired results. Creating a chart to track recommendations and outcomes, separate from the IMRT minutes, but updated at meetings, might provide an easier system to follow to assure recommendations are followed to conclusion and outcomes evaluated for success. The Facility was not in substantial compliance with this provision. It will be important for the Facility to follow its policy for addressing recommendations and provide the documentation of each step that is accomplished, including evidence that the intended outcomes was achieved. The Facility Self-Assessment found this provision to be noncompliant as well.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	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. Electronic copies of Unusual Incident Investigation Reports were entered into the electronic AVATAR system. This allowed access by 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.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year,	To conduct this review, the trend reports A/N/E, Unusual Incidents, and Injuries for the months of March and July 2013 were examined.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Metric D.4.1: For all unusual incident categories and investigations, the Facility did not have a system that allowed tracking and trending by: ▪ Type of incident; ▪ Staff alleged to have caused the incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. Although the Facility was tracking unusual incidents according to many of these parameters, there was no provision for tracking of the outcomes of Facility-Only investigations. Outcomes such as need for additional training, changes to ISPs, and need for new or clearer procedures needed to be tracked and trended in order to determine where corrective action might be needed to prevent future problems. Over the past two quarters, the Facility's trend analyses: ▪ Metric D.4.2: Were conducted at least quarterly; ▪ Metric D.4.3: Did not address the minimum data elements (i.e., outcomes of Facility Only investigations were not tracked or trended); ▪ Metric D.4.4: Did use appropriate trend analysis procedures, including graphing data over a rolling 12-month period and using graphics to display data; ▪ Metric D.4.5**:** Did not provide a narrative description/explanation of the results and conclusions; and ▪ Metric D.4.6: Did not**,** as appropriate, contain recommendations for corrective actions. For example, while there were large numbers of injuries for some individuals (notably Individual #348) and a trending upward of injuries between August 2012 and July 2013, there was no analysis to explain the reasons or recommendations for corrective action plans to address the high numbers of injuries. Likewise, there were some individuals who were involved in high numbers of peer-to-peer injuries, yet there were no recommendations for corrective action to address those individuals or investigate the systemic circumstances that might be contributing to the injuries. Metric D.4.7: Based on a review of trend reports, IMRT minutes, and QA/QI Council minutes, when a negative pattern or trend was identified, corrective action plans were not developed. Metric D.4.8: As appropriate, corrective action plans were not developed both for specific individuals and at a systemic level. For example: • The Unusual Incident Trend Report for July 2013 showed an upward trend in the number of UIRs, but there was no narrative to explain the trend or any	

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		corrective action plans to address the trend. Metric D.4.9: The trend reports and/or minutes did not show that corrective action plans were implemented and tracked to completion. Metric D.4.10: The report/minutes did not review, as appropriate, the effectiveness of previous corrective action plans, since no corrective action plans appeared on the CAPs tracking sheet in relation to serious incidents and/or abuse, neglect, and exploitation. The following metrics were not rated since no action plans/corrective action plans based on serious incident trend tracking and analysis were found. However, these metrics will be reviewed during the next monitoring visit: ▪ Metric D.4.11: ___ out of ___ action plans (__%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. ▪ Metric D.4.12: For ___ out of ___ of the action plans reviewed (___%), the plan had been timely and thoroughly implemented. ▪ Metric D.4.13: For ___ out of ___ action plans (___%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. The Facility was not in substantial compliance with the requirements of this subsection of the Settlement Agreement. This was consistent with the Facility's Self-Assessment findings. While the system for tracking and trending data over time was largely in place, there was little analysis of the trends and no response to trends in the form of corrective action plans that were tracked to completion.	
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	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	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 2013. 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 three employees had been terminated based on background checks. In an interview with the Facility Director, his decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, 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.	

<table>
<tr><th>SECTION E: Quality Assurance</th><th></th></tr>
<tr><td>Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:</td><td>
Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

Review of Following Documents:

DADS Policy #003.1: Quality Assurance (QA), dated 1/26/12;
CCSSLC Policy #003.2, dated 5/22/13;
Presentation Book for Section E;
CCSSLC Key Indicators, undated
CCSSLC Corrective Action Plan (CAP) Template, revised 4/18/13;
Completed CAPs, Modified CAPs and Archived CAPs, undated (in response to Document Request IV.7.);
CCSSLC Quality Enhancement Plan, revised 4/18/13;
CCSSLC Self-Assessment, dated 9/13/13;
CCSSLC Action Plan for Section E, dated September 2013;
CCSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation, March 2013 and July 2013;
CCSSLC Trend Analysis Report: Injuries, March and July 2013;
CCSSLC Unusual Incidents Trending Reports, March and July 2013;
CCSSLC Restraints Trend Analysis Reports, March and July 2013,
CCSSLC Quality Assurance/Quality Improvement (QA/QI) Council meeting notes, including section presentations and Program Compliance Monitor (PCM) summaries, dated 2/7/13 to 7/18/13;
CCSSLC Quality Assurance/Quality Improvement Council meeting agenda and handouts, for meeting on 10/3/13;
Monitoring tools associated with the Quality Enhancement Plan that had been revised since the last onsite visit, including: sections D, F, and I and J; and
QA/QI Data Summaries for:
<table>
<tr><td>C: 4/11/13, 7/11/13</td><td>N: 4/11/13, 7/18/13</td></tr>
<tr><td>D: 2/14/13, 5/23/13</td><td>O: 3/21/13</td></tr>
<tr><td>E: 2/14/13, 5/9/13</td><td>P: 3/21/13, 6/13/13</td></tr>
<tr><td>F: 2/14/13, 5/9/15</td><td>Q: 4/25/13</td></tr>
<tr><td>G: 3/28/13, 6/20/13</td><td>R: 3/21/13, 6/13/13</td></tr>
<tr><td>H: 3/28/13</td><td>S: 2/18/13, 5/16/18</td></tr>
<tr><td>I: 3/28/13, 6/13/13</td><td>T: 2/7/13, 5/9/13</td></tr>
<tr><td>J: 4/11/13, 7/11/13</td><td>U: 3/13/13, 5/16/13</td></tr>
<tr><td>K: 4/11/13, 7/11/13</td><td>V: 2/21/13, 5/16/13</td></tr>
<tr><td>L: 6/20/13</td><td></td></tr>
<tr><td>M: 4/11/13, July 2013</td><td></td></tr>
</table>

Interviews with:

Mark Cazalas, Facility Director;

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	○ Brandon Riggins, Assistant Director of Programs; ○ Jon Breseman, Incident Management Coordinator ○ Cynthia Velasquez, Director for Quality Assurance; ○ Beverly Okin-Larkin, System Analyst; ○ John Henley, Unit Director for Atlantic; ○ Program Compliance Monitors; ○ Staff members from various residential locations; and ○ Individuals in various residential locations. ▪ **Observations of**: ○ QA/QI Council Meeting, on 10/3/13; ○ Atlantic Unit Team Meeting, on 10/1/13; ○ Incident Management Team meeting, on 10/1/13; and ○ Residences: #522A, #522B, #522C, #522D, #524A, #524B, #524C and #524D.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E, dated 9/13/13. 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. ▪ The Facility did use other relevant data sources, such as data from CAP tracking sheets, QA activities, PCM activities, and reports and QA/QI Council meeting minutes. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: ○ Did not present findings consistently based on specific, measurable indicators. For example, for Section E.2, the Self-Assessment indicated that the Facility reviewed "collaborative efforts with other departments…" without specifying where such efforts were documented. ○ Did not consistently measure the quality as well as presence of items. For example, for Section E.2, the presence of outcome measures was determined by reviewing whether the outcome-measure column was completed on the CAP, rather than by whether the outcome identified was measureable. ▪ The Facility rated itself as being in compliance with one of the sub-sections of Section E (i.e., Section E.3). This was not consistent with the Monitoring Team's findings. ▪ The Facility data did identify some areas in need of improvement. For example, for Section E.1, the Facility found that the QA/QI Council should approve and track CAPs and provided a reference to an action plan step to remedy issues identified. That Action Step called for modifying the CAP tracking to include the dates of dissemination. ▪ The Facility did include Action Steps for Section E. However, all but three steps had the same proposed completion date, suggesting the date was chosen arbitrarily, rather than as a predictor of when the step might reasonably be completed.
	Summary of Monitor's Assessment: The Facility was not in substantial compliance with any of the

	subsections of Section E. Since the Monitoring Team's last monitoring visit, the Facility had made some progress with regard to Section E, including: ▪ The QA Plan had been modified to add details about corrective action plans, action plans, and the Quality Assurance/Quality Improvement Council. ▪ There were more CAPs than in past reviews, and it was noted that the Facility Director was encouraging staff to consider CAP development when issues arose during the QA/QI meeting that members of the Monitoring Team observed. ▪ The QA/QI meeting included some data presentations and use of data to drive decisions and to help hold people accountable for completing assessments. ▪ QA/QI Council meetings included a review of outstanding assessments, tracking of attendance at ISP meetings, and an Integrated Risk Rating Form status report. Some of the areas that will need to continue to improve for the Facility to progress toward substantial compliance with the Settlement Agreement included: ▪ While the QA plan had been improved to include a purpose and some clarifications and the matrix had been appended, the plan did not include or append the data inventory (though one had been done), and there were a number of adjustments needed such as adding a section on Key Indicators under the data collection/analysis section and some additional descriptions of the responsibilities of the personnel associated with Quality Assurance. ▪ A list of key indicators was under development, but it was not clear that the list was finalized, what data was being collected, or how the data for the key indicators would be managed, reported, or addressed. ▪ The QA Director needed to take a more direct role in the QA/QI meeting, perhaps providing an overview each month based on the matrix to indicate which sections had completed monitoring, which did not, and where issues were arising in the QA process. ▪ The monitoring tool for Section E needed revision to provide a valid assessment of progress toward substantial compliance. ▪ The CAPs tracking needed to include the method and dates of dissemination, and should not rely on minutes of meetings to convey CAP assignments. ▪ A system was needed to measure whether or not CAPs were achieving the desired outcomes, and, if not making revisions to the plans.

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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	<u>State QA policy</u> There was a State Office policy that adequately addressed all five of the provision items in Section E of the Settlement Agreement. There were no changes to the DADS policy, entitled #003.1: Quality Assurance, dated 1/26/12. The Monitoring Teams' comments on the State Office policy are in the previous monitoring report and are not repeated here.	Noncompliance

#	Provision	Protocol	Compliance
	individuals receiving services and supports.	Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State Office should consider this. Facility QA policies The Facility had added Facility Policy #003.2, dated 5/22/13, to operationalize the State Office policy. It appeared to be consistent with the DADS policy. The policy contained a requirement for maintenance of a list of all data (a data inventory), which addressed one of the concerns noted in the Monitoring Team's last report. QA data list/inventory of data The Facility maintained a data list that identified data for most sections of the Settlement 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 and reasons for amendments to ISPs, quality reviews of the ISPs, or progress on skill acquisition programs (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 Compliance Monitors and section leads, 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, including the name and most recent revision date. ▪ 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. While a list of key indicators was provided, it did not have a date of adoption by the QA/QI Council and data was not identified to track the indicators. 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 related 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 6/26/13. Upon	

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		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. It would be useful if the data list/inventory were arranged by section letter (C, D, E…) rather than by numerals, since that is how the Facility had arranged most of its activity related to the Settlement Agreement. Such arrangement would facilitate cross-walking reports being produced to the data that supported them. <u>QA Plan Narrative</u> The QA plan narrative at the Facility was current. The date on the most recent copy of the Quality Assurance Plan was 4/18/13. It included improvements over the previous plan, but needed some additional work to be complete. The QA Plan described the QA program, including: ▪ A description of the purpose of the QA program, ▪ The organizational structure of the QA process was described, including an organizational chart for the QA Department. ▪ The data list/inventory was available, but not appended or attached to the plan and not provided as part of the QA plan. ▪ The QA matrix was included. ▪ Key indicators of performance were not included in the plan or in the matrix. ▪ A description of how data were summarized was included, but did not provide information on how the data collected would be analyzed or who would do it. For example, the plan indicated data on abuse/neglect/exploitation would be analyzed and trended, but it was not clear that the analysis would result in explanations of the data trends and include recommendations. ▪ The role of other departments in QA was not clearly described. There was no detail about what was expected of Section Leads. (For example: to collect data using the monitoring tools, to meet regularly with assigned PCMs to review and analyze the data, and to prepare CAPs when needed.) ▪ The QA Council description included a list of quality assurance related committees and the expectations that they report regularly to the Council. ▪ The QA Plan did not describe what reports the QA Director would issue. On interview, it appeared that the QA Director provided information based on the monitoring of sections of the Settlement Agreement to the Section Lead in conjunction with the Lead's quarterly report to the QA/QI Council. This needed to be described in the QA Plan. ▪ QA/QI Council and its role in reviewing data and guiding the entire QA process were included. ▪ A revised description of Corrective Action Plans and how they are developed	

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		was included. QA Plan Matrix: The QA Plan Matrix contained the data to be submitted to the QA Department. These data were then included in the QA report sections of quarterly section updates to the QA/QI Council. While a list of key indicators was provided for all sections, it was not clear that it had been adopted or that data to assess the key indicators had been identified or was being collected. The indicators were general in nature, making it difficult to determine exactly what would be measured and how that would be accomplished. For example, Section E listed four indicators: 1) Monitoring Data, 2) Corrective Action Plans, 3) Regulatory/ICF, and 4) Facility Support Performance Indicator. None of them provided additional descriptions. As a result, it could not be determined if the Facility had developed an adequate set of quality indicators. However, based on that list, the following observations were made. While trend reports were provided for abuse/neglect/exploitation, injuries, unusual incidents and restraints, these reports or related key indicators did not appear on the matrix. For the 20 sections of the Settlement Agreement, a set of key indicators was included for 20 of the 20 sections (100%). Of these 20, both process and outcome indicators were identified for nine (45%) of the sections. ▪ Of these nine, in none (0%) 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. The key indicators were not specific enough about what would be measured to determine if data would be produced that could be trended as anticipated by this metric. Self-monitoring tools for all Settlement Agreement provisions: The QA plan matrix included self-monitoring tools or self-monitoring procedures for the 20 sections of the Settlement Agreement. However, at the Monitoring Team's last review, it was noted that copies of tools were not provided for sections L, N, Q, and R, although they were listed in the matrix as having tools. These tools were not provided during the current review. It was learned through interview that the Section M tools had been revised and the	

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		number of tools reduced. There was no indication of this change on the matrix. Tools for sections D, F, J, U, and I were provided and appeared to be revisions of previous tools. However, the dates of the last revision were not included in the tools. The PCM indicated a tool was in use for Section R, but it was not provided. 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 and some sections did not appear to have a tool. All Data Collected by QA Department: All data that QA staff members collected were not listed on the matrix. For example, Section M had multiple tools, but this was not clear on the matrix. Section F had two tools, but only one was listed on the matrix. Section T had multiple tools, but only one was listed. *Includes Satisfaction Measures and Follow-up Surveys had been done of families/LARs at the rate of 22 surveys per month. Response levels averaged 3.5 per month. Two issues identified related to communication and condition of clothing. It was not clear what steps had been taken to address these issues. A survey of staff had been done, but it was not clear what response would be made to staff based on the results. All Items in QA Plan Matrix Also Appear in the QA Data List/Inventory: 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, and it was not clear if this sub-heading did include all of the monitoring data. All data in QA plan matrix are submitted and received Of the 20 items in the QA plan matrix, nine (45%) were submitted to/collected by/received by the QA Department for the last two reporting periods for each item as evidenced by the PCM Summary reports provided at quarterly reviews. The sections that were submitted included: C, E, J, K, P, R, S, U, and V. Those that did not were: G, H, I, L, and Q. Those that were submitted for one quarter only were: D, F, M, N, O, and T. Data in the QA Plan were Reviewed and Analyzed: Of the 20 items in the QA matrix, 9 were documented to show review or analysis by the QA department and/or the department section leads for the last two reporting periods (quarterly reviews) as described above. The quality of these reviews is discussed with regard to Section E.2. Implement the QA Plan as Written: There were 33 separate tasks enumerated in the QA	

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		Plan, and an additional 20 in the matrix, and other tasks were listed, but not numbered. From the data available, it was not possible to determine if each of these tasks were fulfilled. Generally, the plan requirements were being addressed as noted in the applicable discussions in this report. However, a few, such as those related to development and review of corrective action plans, were not documented to allow for review of whether corrective action plans were designed to remedy and/or prevent recurrence of the target issue, or whether all important changes were considered. QA Staff Assist Disciplines/Departments in Analysis of Data For the 19 sections of the Settlement Agreement (Section E excluded), PCMs reported that they assisted four (F, O, R, and S) section leads with analysis. For those sections without documentation of assistance, there was no documentation of the reasons that assistance was not needed. Moreover, while many of the reviews summarized monitoring data, few 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. As the QA Director and the Department section leads 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: ▪ 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 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.) While this area was not evaluated, one example of monitoring tool validity was evident and illustrates the importance of tool validity. The Facility's results for the June monitoring of Section E indicated 100% compliance with all five provisions of the Settlement Agreement's Section E. Yet, in its Self-Assessment, the Facility found noncompliance in four of the five provisions. Clearly the Section E tool is not a valid measure of compliance and needs to be revised. ▪ 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.) ▪ Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. [Metric to be measured: Since the last onsite	

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		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).] ▪ 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 Settlement Agreement, 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 plan narrative needed additional work; the matrix needed to include: trend reports for abuse/neglect/exploitation, injuries, unusual incidents and restraints, as well as key indicators and accurate descriptions of the various monitoring tools in use; the data inventory needed work to identify where data from the monitoring tools was being collected; and a method for documenting assistance provided to discipline heads by PCMs needed to be in place and implemented. In addition, the Quality Assurance Department needed to attend to the other items in this provision that were not fully performing. The Facility found noncompliance its Facility Self-Assessment.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	**Data and QA Reports** To determine if the data from the QA plan matrix had been summarized, graphed and analyzed, the electronic file IV.6 provided in response to the document request was examined. The month examined was June 2013 for each section. The review included the summaries (usually the PCM summary for the closest month to June), graphs, and analyses to determine if data had been reviewed across the elements the Settlement Agreement requires. Data from the QA plan matrix for none of the 19 (0%) sections of the Settlement Agreement (not section E) were: ▪ Summarized; ▪ Graphed showing trends over time; and ▪ Analyzed across a) program areas; b) living units; c) work shifts; d) protections, supports, and services; e) areas of care; f) individual staff; and/or g) individuals. However, there were considerable differences between the sections. The file did not contain information for eight sections (C, D, G, H, K, L, M, N, and Q), although data summaries were present in other files for these sections such as in QA/QI Council minutes. For those sections that were included, some had more comprehensive analyses	Noncompliance

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		of data with trending over time such as section S. Others had analyses that included recommendations (e.g., O, P, and R relative to the findings of the monitoring rather than the process of conducting the monitoring.) While the file did not contain evidence that all sections had been monitored in June or at the nearest quarter, the fact that there were notable differences between this file and others such as the QA/QI minutes, suggested that more were likely completed than were found in the file. Trend reports (abuse/neglect/exploitation, injuries, unusual incidents, and restraints) were not included in the file, but were available in other files. These trend reports summarized data, graphed it over time, and provided some analysis. However, there was little narrative or recommendations in the reports. A key to making this process useful is that 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 results in the identification of common issues and/or underlying causes of those trends or issues. **Regular Meetings Between Discipline Department and QA Staff** The QA Director and the PCMs reported that most met weekly to reconcile findings on samples and to discuss any issues that emerged or that disciplines asked to discuss. However, formal minutes of the meetings were not being kept. <u>Review QA Related actions</u>: Based on a review of a sample of five of the sections of the Settlement Agreement (F, I, O, P, and V), none had minutes of meetings between QA staff and discipline heads for the last two quarters. However, based on documentation in the PCM monitoring summaries, in the discussions with PCMs, and analyses of data where available: ▪ Since the last on site review, a meeting occurred at least twice for five of the sampled sections (100%) of the Settlement Agreement and all of the five topics listed below were conducted during none of them (0%). o In 0% review of the data listing/inventory and matrix; o In 0% discussion of the data and outcomes; o In 100% review of the conduct of the self-monitoring tools; o In 0% creation/proposal of corrective action plans; and o In 0% review of previous corrective action plans. <u>Data were available</u>: ▪ Since the last onsite review, during five of the five (100%) meetings, data were available to facilitate department/discipline analysis of data. As noted, however,	

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		this finding was based on discussions with PCMs and limited information in files in the absence of meeting minutes. Data were reviewed/analyzed: ▪ Since the last onsite review, during three of the five meetings (60%) data were reviewed and analyzed. Those three were for sections F, O, and V. The remaining two appeared to focus on inter-rater agreement. ▪ Since the last onsite review, during none of the five (0%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. This was determined by reviewing quarterly reports that included summaries of QA monitoring activity, since no minutes of meetings between QA staff and disciplines were documented. **QA Reports** Since the last onsite review, a Facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for six of the six (100%) months. However, the QA reports were in the form of PCM monitoring summaries that were appended to the section reports delivered by the section leads. Of the 20 sections of the Settlement Agreement, 11 (55%) appeared in a QA report at least once in each quarter since the last onsite review. What this meant at CCSSLC was that the Section report included a PCM summary at least once in each quarter since the last onsite review. Of the sections of the Settlement Agreement that were presented, 0 of 20 (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 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 **Facility QA/QI Council** Design 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. Schedule, agenda, attendance Since the last onsite review, the QA/QI Council met at least once each month.	

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		Minutes from 19 of the 19 (100%) of the QA/QI Council meetings since the last review indicated that the meetings occurred according to schedule. Minutes from 19 of the 19 (100%) of the QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. A sample was drawn of one meeting in each of the months of March, April, May, June, and July 2013, and attendance was checked against the list of 15 core members that were required to attend according to the QA Plan. In each case from four to six of the 15 core members were missing, usually the Director of Food and Nutrition Services, the Director of Maintenance/Plant Operation, the Medical Director, or a section lead. Generally, from 70% to 80% of the core team members were present. As a result, Minutes from none of the five sampled (0%) of the QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. <u>Data and Analysis Presented</u>: Minutes from none of the 19 (0%) QA/QI Council meetings since the last review documented that: a. Data from QA plan matrix (key indicators, self-monitoring) were presented; b. The data presented were trended over time; and c. Comments/interpretation/analysis of data were presented. However as noted in other parts of this report, trend reports for abuse/neglect/exploitation, injuries, unusual incidents and restraints were available and trended over time, providing considerable data, graphed for ease of use, and with some analysis provided, but did not include interpretation in the form of a narrative or recommendations as to how the results might become CAPs. <u>Recommendations and Corrective Action Plans</u>: In none of the 19 meetings (0%), recommendations and action plans were selected when appropriate to do so and were based on the data presented. **Corrective Actions and CAPs** <u>System for generating CAPs:</u> A written description did not exist that indicated how CAPs were generated, including the criteria for a CAP and a description of how to evaluate indicators for criteria. <u>CAP development</u>: When considering the full set of three current CAPs, none (0%) appeared to have been chosen following a written description policy or procedure. Each had a source for the	

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		issue such as the Monthly Monitoring Tool, an Internal Audit, or the QA/QI workgroup. It was noted that at the QA/QI meeting on 10/3/13, the Facility Director was commenting on presentations and generating discussion about whether CAPs were needed. <u>Content of each CAP:</u> A sample of current and completed/modified CAPs were selected, including:	

Sample ID #	Date of CAP	Listed as:	Topic
E1	9/18/13	Current	Data documentation
E2	12/21/12	Current	Desensitization plan process
E3	1/24/13	Current	Family participation in education re: living options
E4	5/15/13	Completed	Engagement
E5	5/1/13	Completed	Update physicians on standards of care
E6	3/3/13	Completed	Quality of monthly reviews
E7	5/15/13	Modified	Dental refusals
E8	3/15/13 (Pacific)	Modified	Community participation
E9	3/15/13 (Coral Sea)	Modified	Community participation
E10	3/1/13 (Coral Sea)	Modified	Community participation

Of the 10 CAPs the Monitoring Team reviewed, six (60%) appeared to address the specific problem for which they were created. Those that did not included:

- Sample #E2: There was only one action step and that step reiterated the need for a CAP to correct data collecting and recording discrepancies.
- Sample #E3: The CAP addressed the issue of improving participation of families and LARs in education regarding living options with only one action step, to contact other Facilities for strategies. The CAP needed additional steps to explain how any discovered strategies would be used to encourage family participation and to explore additional possibilities for providing encouragement.
- Sample #E5: The CAP addressed the issue of updating physicians on standards

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		of care by instituting a monthly lunch journal club. There were no steps to explain how this would be done or what it would include, whether staff would be expected/required to attend, or any other details related to establishing the club. ▪ Sample #E8: The CAP was not clear as to the steps needed to have direct support professionals conduct SAP training in community settings. It was noted that the one step on the tracking sheet was numbered "3," which could mean there were originally more steps. <u>CAPs contain all necessary components:</u> Based on the sample of 10 CAPs, which represented 48% of the total of 21 CAPs, listed as current (three), completed (three) and modified (15): ▪ Six (60%) included the actions to be taken to remedy and/or prevent the reoccurrence. Those that did not were Sample #E2, #E3, #E5, and #E8. ▪ Two (20%) included the anticipated outcome of each action step. Those that did were Sample #E1 and #E9. The remaining did not provide a measurable outcome or a baseline against which to judge progress. ▪ Four (40%) included the person(s) responsible. Those that did include one or two people as responsible were Sample #E4 (included specific names), #E5, #E6, and #E10. The rest named entire departments or lists of people, making it difficult to identify who was charged with making sure the CAP was completed. ▪ Five (50%) included the time frame in which each action step must occur. Those that did not were Sample #E1 (a six month timeframe with no provision for interim checks), #E2 (a year-long project with no interim steps), #E3 (a six-month project with no interim checks), #E8 (with a 16-day timeframe, which did not appear to allow for any evaluation of the effectiveness and raised the question of whether a CAP was needed for an action that would take two weeks) and #E9 (no time frame indicated.) Based on the review conducted that found inconsistent reviewing, analyzing and presenting data; unclear linkage between data analysis and the corrective action plans; 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. The Facility made similar findings in the Facility Self-Assessment.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a sample of ten CAPs, which represented 48% of the total of 21 CAPs: there were: ▪ Ten (100%) that included documentation about how the CAP was disseminated; ▪ None (0%) that included documentation about when each CAP was disseminated; and ▪ Four (40%) that included documentation indicating to whom it was	Noncompliance

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		disseminated, including specific person(s) responsible. The four that did were Sample #E.4, #E5, #E6, #E10, those being the CAPs where the person responsible was clear. It appeared that the dissemination process changed at some point from using emails to notify participants to relying on minutes of meetings for dissemination. Use of minutes might not be effective, since it is possible that individual staff involved in CAPs would not read the minutes or that the distribution of minutes could be delayed. If use of minutes will be the process, care should be taken to document the time the minutes were distributed and explain how key participants in the CAP will be notified. The Facility was found not to be in substantial compliance with this provision since at least 90% of the CAPs were not disseminated as required. The Facility found substantial compliance in their Self-Assessment, but it was not clear what documentation formed the basis of their review. If the Facility had documentation of the dissemination of CAPs that covered all three points listed in this review, that documentation should be provided at the next review.	
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.	Implementation of CAPs: Based on a sample of three completed CAPs and seven in process CAPs (i.e., as identified in the table included in relation to Section E.2,) four (40%) were implemented fully and five (50%) were implemented in a timely manner. Those that were fully implemented included: ▪ Sample #E1: the date of this review was prior to the date of any of the steps; ▪ Sample #E4 and #E5, which were complete and the steps were reported timely; and ▪ Sample #E6: an extension was entered timely. The remaining six had issues ranging from lack of clarity as to what steps were taken (e.g., #E2) and no indication of current progress where timeframes extended over several months (e.g., #E3), or the CAP was past its due date with no update (#E7 to #E10). Tracking CAP status: There was a system for tracking the status of CAPs, which consisted of a column on the tracking sheet for comments/additional recommendations/actions. Of the 10 CAPs in the sample being tracked by the Facility, for three (30%) the tracking sheet indicated the status of the CAP and any action taken if a CAP had not been implemented. Those three were Sample #E1, #E4, and #E5. The rest sometimes had comments, but they were not up-to-date, or might have been complete, but there was no entry to indicate completion, or there was nothing in that column.	Noncompliance

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		Management of CAPs: The Facility QA director: ▪ Did maintain summary information/data regarding CAPs and their status (number of CAPs and number overdue) that was updated within the month prior to the onsite review in the sample of CAPs; and ▪ Did present this information to QA/QI Council at least quarterly. The Facility was/was not in substantial compliance with this provision. The Facility also indicated a finding of noncompliance in their Self-Assessment.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Evaluate effectiveness of CAPs: 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 QA/QI 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. CCSSLC was not in substantial compliance with this provision. The Facility reviewed "data related to CAPs" to determine that this provision was not in substantial compliance in its Facility Self-Assessment. However, no data was presented as evidence that the requirements of this provision were satisfied. To move toward substantial compliance with this provision the Facility will need to: ▪ Show that the outcome for each CAP is measureable and provide evidence that it was measured; ▪ Show that, as appropriate, the QA/QI Council recognized the need to modify a CAP through its minutes; ▪ Show that each step of the CAP was completed timely, or an extension was requested and approved; and ▪ Document that the CAP was completed and when/how the outcome was checked to be certain it was having the desired effect.	Noncompliance

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** 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 9/13/13; o Action Plan for Section F; o CCSSLC Provision Action Information for Section F; o Draft Individual Support Plan (ISP), Physical and Nutritional Management Plan (PNMP), Communication Dictionary, and Integrated Risk Rating Form (IRRF) for Individual #70 and Individual #333; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11; o Settlement Agreement Cross Referenced with ICF-MR Standards: Section F – Individual Support Plan Meeting and Documentation Monitoring Checklist, undated; o CCSSLC Individual Support Plan checklist, implementation date 7/2013; o A list of Qualified Intellectual Disability Professionals (QIDPs) who have been deemed competent in meeting facilitation; o CCSSLC QDDP Listing with current caseload totals, undated; o Compliance and Inter-Rater Reliability data for January through May 2013; o Compliance Inter-Rater Reliability Scores, for June 2013 through July 2013; o Summary Compliance and Inter-Rater Reliability Scores for June through August 2013; o Corrective Action Plan for Section F; o Corrective Action Plans for Section S; o Programming Review Committee Minutes, dated 5/7/13, 5/21/13, 5/28/13, 6/4/13, 6/18/13, 7/23/13, and 7/30/13; o ISPs and rating sheets for Programming Review Committee on 10/1/13; o Admissions Placement and Training, undated; o ISP Meeting Guide and Instructions for ISP Meeting Guide, revised 5/29/13; o DADS SSLC Policy Number 017, effective 8/1/13; o CCSSLC Integrated Protections, Services, Treatments and Supports policies revised since last review, including: ▪ F.10 – ISP Monitoring/Monthly Review Process, implementation 5/2/13; and ▪ F.22 – Programming Review Committee, implementation 7/3/13' o Last 10 monitoring tools completed by the QIDP 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 Completed Individual Support Plan checklist for Individual #150; 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 8/1/12 through 7/31/13; 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), (ISPAs), Integrated Risk Rating Forms (IRRFs), Integrated Healthcare Plans (IHCPs), Preferences and Strengths Inventory (PSI), Rights Assessments, decision-making capacity assessment, Community Living Options Information Process (CLOIP) 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 #97, Individual #353, Individual #13, Individual #46, Individual #61, Individual #269, Individual #183, Individual #9, Individual #290, and Individual #367; 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, QIDP Coordinator; o Nora Garza, QIDP Educator; o Kimberly Benedict-Rodriguez, Director of Education and Training; and o Araceli Matehuala, Program Compliance Monitor. ▪ **Observations of**: o ISP meetings for Individual #70, Individual #92, and Individual #333; and o Programming Review Committee, on 10/1/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F, dated 9/13/13. 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 had continued to revise its monitoring/audit tools for Section F. At the time of the review, CCSSLC was using a revised version of the Individual Support Plan Meeting and Documentation Monitoring Checklist. The audit tool focused on pre-meeting activities, and the ISP meeting. A second tool had been developed entitled Corpus Christi State Supported Living Center Individual Support Plan, which was designed to review the ISP document. Staff began using it in August 2013. Based on review of the Self-Assessment, it also appeared other reviews were being conducted, for example, of assessments and ISPs

	for Section F.1.c and F.1.d, but it was not clear if a audit tool was used for these reviews. o Based on a review of the Individual Support Plan Meeting and Documentation Monitoring Checklist audit tool and Individual Support Plan tool, they included many important questions/probes that should be helpful in identifying areas of best practice, as well as areas requiring improvement. However, they did not identify all of the necessary indicators to measure compliance. The Facility is encouraged to review the Monitoring Team's report to identify additional indicators. o Since the last review, the QIDP Coordinator and PCM had developed guidelines for the audit tools. They helped to provide some criteria for the reviews. However, as noted in the last two reports, 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 employment/day programming, discuss the Integrated Risk Rating form as a team…)." 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. Even with the additions of the guidelines, it was not always clear what the standards for quality were. For example, with regard to the employment/day programming discussion, the guidelines read: "did the IDT know where the individual worked, what they do at work or day programming? Did they know their schedule?" The guidelines related to recommendations related to work read: "did the IDT come up with any ideas to assist the individual in this area?" Although these were important questions, they did not identify the standards for a quality team discussion about employment and subsequent action plan. For example, would the expectation be that the team would discuss the most integrated employment/day activity setting for the individual, as well as the expectation that individuals would participate in off-residence activities for a full day, unless specific justification was provided? Would the expectation be that a full description of vocational/day program activities would be reviewed, including the development of sufficient skill acquisition programs to define the training that would be provided? Based on review of the Individual Support Plan audit tool, it used a rating scale from zero through two, and for each indicator, these ratings were defined. Sometimes, the criteria left gaps, and it was unclear how items would be rated if they fell between criteria (e.g., "recommendations from the Functional Skills Assessment based on self-help skills are included" and "only half the recommendations are included," making it unclear what score would be given if between half and all were included). Similarly, it was unclear in sections for which ISPs might include more than one of the same item (e.g., plans to address rights restrictions, action plans, etc.), how ratings would be assigned. For example, in the action plan section, it was unclear if the ratings would be based on all action plans, or if each question would be rated for each action plan. 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 QIDP Coordinator. 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, they were working on establishing it. ▪ The Facility used other relevant data sources. For example, the Facility maintained a database to track the timeliness of assessments, as well as spreadsheet to track 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. ▪ 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: CCSSLC continued to develop and implement training to improve the Individual Support Plans (ISPs) for the individuals it served, as well as to take other steps to develop integrated plans. Some examples included: ▪ In June 2013, the Qualified Intellectual Disabilities Professional (QIDP) Coordinator provided training to interdisciplinary teams (IDTs) on each of the Units. Scenarios were used to prompt discussion from the teams about writing ISPAs, including related action plans. This was an innovative approach to try to expand teams' skills in this area. ▪ In August 2013, all IDTs participated in training on the At-Risk process that CCSSLC had developed. It incorporated information about the general ISP process, as well as in-depth information about the IRRF and IHCPs. As noted above, it provided a good structure for teams to use when developing action plans. ▪ In May 2013, the Programming Review Committee began meeting. This was an example of good

	coordination between the QIDP and Active Treatment Departments. The group met weekly and reviewed two individuals' ISPs and monthly reviews. Based on observation during the week of the onsite review, this offered a respectful peer review opportunity for the monthly reviews and ISPs. The Facility is encouraged to continue this practice and even expand the scope of the review to include additional requirements for a comprehensive ISP, such as the quality of action plans. ▪ Timeliness of assessments as well as 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. The following are some of the areas in which concerted efforts were needed to move towards substantial compliance: ▪ 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. ▪ 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. ▪ The Facility recently was using the Integrated Health Care format, which often 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. ▪ Action plans included more measurable action steps, which was positive. Although some limited improvement was seen, 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 recognized this was an area needing improvement, but 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 QIDP and QA Departments continued to work together to revise the tools they used to monitor ISP meetings, as well as ISP documents. Since the last review, they had made good progress on developing guidelines for the tools, but these still required refinement. Efforts were in the initial stages of analyzing the data, and determining if current action plans were sufficient or if additional ones needed development.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two	On November 20, 2012, DADS State Office issued Policy #004.1: Individual Support Plan Process. Comments regarding the policy are included in the subsections to which they apply.	

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	years, the IDT for each individual shall:	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. The Facility had issued some revised policies, and continued to update its local policies related to Section F requirements. 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, CLOIP worksheet, 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 QIDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. A sample of 10 plans was selected from different QIDPs and teams, and included plans for: Individual #97, Individual #353, Individual #13, Individual #46, Individual #61, Individual #269, Individual #183, Individual #9, Individual #290, and Individual #367.	
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 ensured that members of the team participated 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 QIDP 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 QIDP, including activities before, during, and after the ISP meeting. This policy defined the QIDP's role in notifying team members required to attend the meeting of the date and time, as well as the QIDP and Lead QIDP's responsibility for ensuring that necessary assessments were submitted, and if assessments were missing, taking action to obtain them. ▪ The QIDP Coordinator confirmed that QIDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QIDP was the team leader and responsible for ensuring team participation. ▪ An important role of the QIDPs was assisting individuals and their guardians to participate in the meetings. During the onsite review, in the meetings for Individual #333 and Individual #70, neither individual had a guardian nor did family members participate. The individuals attended portions of their	Noncompliance

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		meetings, and, at times, as appropriate the QIDPs sought input from them. ▪ With regard to staffing, the Facility had a QIDP Coordinator and two Lead QIDPs, as well as a QIDP Educator. A total of 13 QIDP positions resulted in a QIDP being assigned an average caseload of 18 individuals, with a range of nine to 22. One of the challenges continued to be the turnover in QIDP positions. Since the last review, the QIDP Coordinator reported that six new QIDPs had started. This represented 46% of the direct-line QIDP workforce. Sometimes, QIDPs were promoted within CCSSLC. Although this was positive for other departments, it resulted in constant retraining of QIDPs. This likely impacted the speed with which the necessary changes could be made in the ISP process. ▪ 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 QIDPs, and it included a competency-based component. At the time of the most recent review, the QIDP Educator, and two QIDPs had been deemed competent in meeting facilitation. One of these QIDPs had recently resigned. ▪ The QIDP Coordinator and QIDP Educator attended four ISP meetings each month. As evidenced in the meetings the Monitoring Team observed, they provided technical assistance to the QIDPs and the teams. Sometimes, this occurred during the meetings, but they also met with teams after the meetings to share more in-depth feedback related to their findings from the monitoring tool. ▪ In May 2013, the Programming Review Committee began meeting. This was an example of good coordination between the QIDP and Active Treatment Departments. The group met weekly and reviewed two individuals' ISPs and monthly reviews. The individuals selected had had ISP meetings three months prior, allowing time for the QIDP to complete the ISP document and at least one monthly review. The QIDPs that had developed the ISPs participated, as well as QIDP Coordinator, Director of Education and Training, Lead QIDPs, the QIDP Educator, and Program Coordinators. The documents were provided ahead of time, and team members were expected to complete a monthly review assessment tool and come to the meeting with comments prepared. Based on observation during the week of the onsite review, this offered a respectful peer review opportunity for the monthly reviews and ISPs. The Facility is encouraged to continue this practice and even expand the scope of the review to include additional requirements for a comprehensive ISP, such as the quality of action plans. It was anticipated that next steps would be establishing inter-rater reliability with the tool, aggregating and analyzing data collected from this process, and identifying and acting on any problematic trends identified. ▪ In August 2013, the Facility began implementing the new ISP format, dated 5/29/13. The QIDP Coordinator and QIDP Educator had added some additional prompts to the format. The format changed the flow of the meeting, and seemed to be assisting teams to focus on individuals' independent living skills, and living	

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		and work and day program options, as well as their risks. Although as discussed while on site, it appeared that the revised format of the ISP helped teams to more fully discuss non-risk items by putting them first on the agenda, depending on the individual, it might make sense to have the risk discussion first. ▪ During the week of the review, the Monitoring Team observed three team meetings, including those for Individual #333, Individual #70, and Individual #92. 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. 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. 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. For example, for Individual #70, the team discussed changes that needed to be made to his PNMP. o At the beginning of the meeting, the QIDP for Individual #70 provided a good description of how the team should make use of the strengths and preferences of the individual. The team made some good use of this information. For example, the team used his strength of eye gazing in a community exposure goal and incorporated some of his preferences as well into the activities for this same goal, such as going to the bookstore or an Asian culture museum. Similarly, the team used his strength of imitating other's actions in developing a skill acquisition plan (SAP) related to turning the pages of a book and counting. o Based on observations on site, as well as review of ISP documents, QIDPs 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. 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 this continued to vary from team to team. 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.	

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		Areas in which improvements should be made in order to achieve compliance, included: ▪ As noted above, one of the current 14 QIDPs and the QIDP Educator had been deemed competent with meeting facilitation. ▪ Based on limited observations of meetings held the week of the onsite review, areas in which QIDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: o Continuing to expand the depth of the preferences identified for individuals. QIDPs 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 Similarly, identifying a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. 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, the team for Individual #70 did not review the Integrated Health Care Plans and/or make revisions based on the team's discussion. Despite the QDDP Coordinator, who was observing, prompting the team to review the IHCPs, the team did not. The team did not discuss measurable objectives or clinical indicators to assist them in determining whether Individual #70 was remaining stable, doing better, or doing worse. o Ensuring that day and vocational options are fully discussed, and plans reflect individuals' strengths and needs and set forth a full day of out-of-home activities, unless justification is provided. For example, although Individual #70 was doing well going to a day program for two hours two days each week, the team did not discuss expanding these hours. No medical or other reason was given for Individual #70 not participating	

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		in full day programming. On a positive note, one team member asked about the possibility of an assessment to determine if he could become involved with paper shredding vocational activities. It was noted that although he did not like hand-over-had assistance, he potentially could learn to push paper through on his own. o Setting forth clearly the methodologies or how outcomes will be accomplished. o Focusing teams on defining measurable, functional objectives during team meetings. Although progress was seen with regard to measurability and the development of objectives that would inform the team about the individual's status, this continued to be an area requiring focused efforts. o Assisting teams to articulate meaningful outcomes for individuals. ▪ Although work was still needed in this regard, the ISP meetings the Monitoring Team observed were slightly reduced in length from previous recent reviews. And, most importantly, the meetings were more productive than many of those seen previously. As mentioned above, the most recent format for the ISP reversed the order, and had the risk rating discussion at the end. This had a number of pros, because it allowed the teams time at the beginning of the meeting to address the important aspects of the individuals' lives related to living, working, and greater independence. As discussed briefly on site, consideration should be given to individualizing this based on the person's needs, because for some individuals, risk mitigation might be so essential to other components of a person's life that it should be discussed first or in an integrated fashion with the other topics. Based on the Monitoring Team's review, progress had been made. However, based on observations as well as review of ISPs, while some meetings were improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. In addition, many QDDPs were not competent in meeting facilitation skills. 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	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 QIDP, 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.	Noncompliance

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	supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	Attendance requirements now were determined at the ISP Preparation Meeting held 90 days prior to the annual meeting. CCSSLC Policy F.5 included 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 the QIDP to send an ISP Meeting Attendance Memo to notify the team members that they were required to attend the ISP meeting. The Facility maintained a spreadsheet with information on attendance. Attendance requirements were entered based on completed forms from the ISP Preparation Meetings, and attendance sign-in sheets from the ISP meetings. As indicated in the last report, based on data the Facility provided for ISPs held between October 2012 and January 2013, average attendance rates were between 59% and 64%. According to data the Facility provided for the time period between February 2013 and July 2013, notable improvement had been made. Based on the Facility's data, the average attendance rates were between 76% and 81%. However, this data was based on those disciplines the teams had identified as required to attend, and, as noted below, problems continued to exist with regard to the identification of necessary team members and/or teams' justification for not requiring their attendance. Until this is corrected, it will be difficult for the Facility to interpret its data. Based on discussion with the QIDP Coordinator as well as observation of the QA/QI Council during the week of the review, 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 10 ISPs the Monitoring Team reviewed: ▪ For 10 of 10 (100%), at the ISP Preparation Meeting, the team defined the members of the team that should attend the annual meeting. ▪ Eight individuals had strengths, preferences, or needs that potentially required additional team member participation. For none of these eight individuals (0%), the team had adequately justified why such team members' participation was not necessary. Those that did not have adequate justification included: Individual #269, Individual #353, Individual #367, Individual #9, Individual #183, Individual #46, Individual #13, and Individual #290. 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. In addition, at times, teams left it up to Habilitation Therapies to decide which team member should attend. This was not appropriate. The team	

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		should have identified the therapy area(s) in which the individual had needs, and required the attendance of the corresponding therapist. ▪ For one individual (10%), the team members the team identified at the ISP Preparation meeting as required attended the meeting. Those individuals for whom this did not occur included: Individual #269, Individual #353, Individual #97, Individual #367, Individual #9, Individual #61, Individual #46, Individual #13, and Individual #290. ▪ For one of the 10 (10%), it appeared that a duly constituted team participated in the annual meetings (i.e., Individual #183, for whom the team failed to identify the need for a member of the psychiatry department or provide adequate justification, but a member of the department attended). The Facility continued 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 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 continuing to identify issues with attendance of identified team members and address them during the QA/QI Council meetings. This appeared to be having an impact in improving attendance for a number of disciplines. 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.	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. ▪ 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. ▪ In reviewing a sample of ISPs, individuals' teams were identifying necessary assessments at the ISP Preparation Meetings. Generally, teams were requiring a full battery of assessments for each individual. Areas of concern included: ▪ The Facility was tracking the timeliness of assessments. Based on the data generated for ISPs meetings held between August 2012 and July 2013, some improvement was noted, but significant issues continued to exist with regard to the timeliness of assessments from specific disciplines. For example, for the month of July 2013, specific disciplines' performance ranged for 26 to 100 percent compliance, with an average for all disciplines of 79 percent. In some	Noncompliance

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		ways, this was an improvement from June 2013, when the range was zero to 100 percent, with an average for all disciplines of 72 percent. Significant variances were seen with regard to various disciplines. For example, using these two months: psychiatric assessment timeliness increased from eight percent in June 2013 to 100 percent in July 2013, while physical/medical assessment decreased from 67 percent to 26 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 with regard to the sections of the Settlement Agreement that address nursing services (Section M), and vocational, habilitation and skill acquisition (Section S). Some assessments in which improvements were seen included psychology, psychiatry, OT/PT, physical and nutritional supports (Sections O), and speech and language assessments. During the week of the review, the Monitoring Team was given a copy of a packet of assessments State Office had issued. The three Monitoring Teams have not yet fully reviewed them. 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. ▪ Another issue identified was related to the listing of the individuals' strengths and needs in assessments. Although many assessments now listed them, there was little evidence that assessors had incorporated them in meaningful ways in the resulting recommendations. Based on the sample of 10 ISPs: ▪ For 10 individuals (100%), at the ISP Preparation Meeting, the team defined the assessments that were needed for the annual meeting. ▪ In reviewing the ISPs for 10 individuals, the teams for 10 individuals (100%) 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. As noted above, generally, teams identified most assessments as requiring completion ▪ For none of the 10 (0%), the necessary assessments were completed and available to the teams at least 10 working days prior to the ISP meeting.	

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		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 teams were consistently using the ISP Preparation Meeting to identify the assessments needed for the annual ISP meetings, 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 the protections, services, and supports to be provided to the individual.	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 assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 10 plans (0%) 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. ▪ 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.	Noncompliance
F1e	Develop each ISP in accordance	Based on information the Facility provided, the following activities had occurred to	Noncompliance

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	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).	provide education to QIDPs regarding community living options: ▪ As discussed with regard to Section T, New Employee Orientation 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. Based on the review of the sample of 10 ISPs, 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 ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the 10 ISPs reviewed, for five (50%) (i.e., Individual #269, Individual #353, Individual #97, Individual #183, and Individual #61), all of the assessments included the applicable statement/recommendation. For the remaining individuals, the assessments that did not include recommendations included: the Functional Skills Assessment, psychiatry, education and training, and nursing. Of note, at times the statements that were included either did not follow the State Office format. Of concern, some of the psychiatric assessments in particular showed a lack of understanding of individuals' right to live in the most integrated setting. For example, for Individual #13, the following statement was included: "I may add that he is a high-functioning individual capable of moving out into a group home, which would be convenient for him to go an visit his parents, unless he becomes a nuisance for the family members, in which case he should be here or in San Antonio State School, which is closer to his parents' home." o Of the 10 ISPs reviewed, two of the individuals had been referred for transition to the community (i.e., Individual #353, who previously had been referred and the team continued the referral, and Individual #61). For the remaining eight individuals, seven individuals' ISPs (88%) included a recommendation from the professionals on the team to the individual and LAR. The one that did not was Individual #367. For only three of these individuals (43%) was adequate justification provided (i.e., Individual #97 and Individual #13, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #269 for whom the team recommended transition). The following provide examples of inadequate justification for teams' conclusions:	

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		▪ For Individual #9, the ISP listed only some of the assessment recommendations, but all of those listed indicated that Individual #9 could be supported in a less restrictive setting. The professional members of the team recommended that he not be referred, but no justification was provided for team members changing their initial recommendations. The explanation provided largely revolved around the team not knowing what the individual's preferences were. He did not have a guardian. Although the team indicated his family wanted him to remain at CCSSLC and to be "a voice" in his life, another section of the ISP indicated that he "does not have involved interactions with his family. It has been sometime [sic] since he has seen his family." The team indicated he refused to get in a van to leave CCSSLC. However, it was unclear if it was the van itself or riding in it that he did not like, or if this was an indication that he wanted to remain at CCSSLC. ▪ For Individual #183, according to the ISP narrative, all assessments submitted included a statement indicating he could be supported in a less restrictive setting. However, without justification, the professional members of the team recommended that he not be referred for transition. The professional members of the team indicated Individual #183 could not communicate verbally, so his preferences were not known, and they could not get in touch with the family to discuss options. He did not have a guardian. ▪ The narrative of the ISP indicated that all of the assessments included statements that Individual #46 could be supported in a less restrictive setting. However, without justification, the professional members of the team indicated that they did not recommend transition to the community. The ISP narrative indicated that this was based on the family/guardian's preference. This recommendation should have been made independent of the individual and guardian, and then the overall decision should have incorporated the wishes of the guardian. ▪ For Individual #290, the ISP summarized the statements made in the assessments, and indicated that all but two discipline members believed he could be supported in a less restrictive setting. The two that did not were psychiatry and audiology. This was not consistent with the Monitoring Team's review of	

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		the actual assessments, because these assessments either did not include a statement (psychiatry) or indicated he could be supported in a less restrictive setting (audiology). Although no discussion to remedy these different opinions or provide justification was documented in the ISP, the discipline members concluded that Individual #290 would not benefit from transition to the community. o In ten of the ten (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. However, of these, five (50%) included appropriate justification (i.e., Individual #353 and Individual #61 who were appropriately referred; Individual #97 and Individual #13, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #46, whose guardian made the final decision not to make a referral). Examples of concerns included: ▪ For Individual #269, the professional members of the team recommended that she be referred for transition, because her "needs can be met in a less restrictive setting." However, the overall conclusion was that she not be referred. The only obstacle identified was individual choice due to lack of understanding of community living options. In the rights section of the ISP, the team indicated that: "Due to her profound intellectual developmental disability, [Individual #269] is unable to give informed consent in the areas of medical, programmatic... Her IDT along with input from her family make these decisions for her." It was unclear how the team expected this would change, or how Individual #269 would overcome her lack of understanding of community living options. Given that the discipline team members agreed she could be supported in a less restrictive environment, she should have been referred. ▪ The ISPs for Individual #290, Individual #183, Individual #367, and Individual #9 did not include adequate justification for the teams' decisions. ▪ 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 the LAR's choice not to pursue transition to the community. Action plans generally had been	

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		developed, but they were not sufficiently individualized. ▪ QIDPs 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. This remained a work in progress. As individuals' ISPs grow 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 regard to individuals' appropriateness for community transition, and making recommendations to the individuals and/or LARs, these recommendations 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	Noncompliance

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		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' preferences. Teams at CCSSLC continued to utilize the Preferences and Strengths Inventory. Based on review of the sample of 10 ISPs: ▪ All 10 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. Some teams had begun to include some preferences and strengths related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. It will be important for teams to continue to expand these lists and define what it is the individual prefers about them to be able to offer the individual new experiences based on this information. ▪ None of the individuals' teams (0%) had effectively incorporated their preferences into related action plans. Often, teams used preferences as a continuation of what the individual already was doing (e.g., interacting with family, or engaging in preferred leisure activities), as opposed to as a way to expand the individual's opportunities. Of note, at the ISP meeting the Monitoring Team observed for Individual #333, the team talked about using some of his preferences, for example, for playing ball or Frisbee, to encourage him to walk. This was a good example of incorporating preferences into programs or treatment to improve the individual's health, well-being, and independence. ▪ 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. Of note, in the ISP for Individual #97, some minimal discussion was included about why one program or skill area was chosen over another. However, overall, although the ISP Preparation Meeting documentation now included a list of goals the team had decided upon, no explanation was provided	

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		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 10 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, and/or implemented plans to address them. <u>Identification of Supports Needed to Encourage Community Integration</u> Based on a review of individuals' ISPs: ▪ Nine of the 10 ISPs (100%) included specific skill acquisition action plans for implementation in the community. The one that did not was the ISP for Individual #97. ▪ Two of the 10 individuals' ISPs (20%) included at least one measurable objective to enhance individuals' participation and integration into their communities. Individual #61 had two community skill acquisition programs: learning to use the bus and the library. Individual #46 had a goal to learn to purchase healthy food in a grocery store. 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. Most 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, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the	The action plan section of the ISP was where measurable goals/objectives, the 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.	Noncompliance

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	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;	The Facility staff recognized that this was an area in which additional training and technical assistance was needed. Since the last review, the Habilitation Therapies Director developed and provided training on the "At Risk" Process: the IRRF and IHCP. This training is discussed in further detail in relationship to Section I. However, based on review of the section of the training related to IHCP action plans, it provided some good information about what teams should think about when developing an action plan, such as the etiology of the problem; steps that can be taken, including action steps related to prevention, direct intervention, and training; measurable data that can be collected to assess efficacy; incorporation of key elements of free-standing plans (e.g., PNMP, BSP, etc.); and making plans measurable by answering the who, what, where, and when questions. In August 2013, the training was completed for all IDTs. The sample of ISPs the Facility provided all were completed prior to this training, so its impact could not be assessed based on the current sample. The following summarizes the findings related to action plans for the sample of 10 ISPs: ▪ None of the 10 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 10 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 generally had been developed, but 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. Clearly, efforts were being made to make them more measurable. For example, in some cases, IHCPs included objectives to allow the team to determine whether the individual was improving [e.g., or for Individual #353, "reduction of the number of falls this year by 50%" (with the stated baseline of 11 falls), or "reduce BMI by 10%; or for Individual #367: "oral hygiene rating will be maintained at good by next scheduled dental appointment," or "will remain free from symptoms related to cardiac issued this year [as evidenced by] maintaining blood pressured under 140/80 and lipid panel within normal	

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		reference range."]. However, all plans in the sample included objectives that could not be measured (e.g., for Individual #353, "Provide appropriate diet monitoring to facilitate weight loss and manage blood sugar levels" or "Positive behavior support plan for SIB," or for Individual #367: "Continue to attend vocational services"). ▪ 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. Integrated Health Care Plans were being developed. However, as observed during the onsite review, some teams discussed them and made revisions during ISP meetings, while others did not. Infrequently, PBSP objectives were included, but often only a reference was made to implementation of the PBSP. Similarly, PNMPs, psychiatric plans, and plans to reduce restraint use were noted as having been "approved" in the ISP narrative, but they were not incorporated into the ISP through the inclusion of measurable goals or objectives. ▪ The action plans teams' developed to address individuals' risk areas generally did not include adequate measurable clinical indicators. This is discussed in further detail with regard to Section I of the Settlement Agreement. However, the lack of these clinical indicators resulted in teams not having a mechanism to measure whether the person was progressing, declining, or remaining stable. Although it was clear the teams were trying to improve in this area, further work was needed to assist teams in identifying adequate, measurable clinical indicators (e.g., goal for blood pressure or parameters for notification of PCP) or outcome measures (e.g., objective for reduction in target behavior or increase in replacement behavior). In addition, teams should consistently identify parameters for when direct support professionals or nurses need to contact the nurse or the PCP, respectively, and/or the team needs to meet to ensure changes in status are adequately addressed. 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,	Noncompliance

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		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 steps were included in the ISPs in relation to plans other than PNMPs. ▪ Delineation was not sufficiently clear of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.). 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 ISP action plans and IHCPs did not consistently include the supports that the team identified in the IRRF or elsewhere in the ISP. Disturbingly, when supports were discussed as necessary for risk factors rated as low, the team did not include these in action plans. ▪ 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 or the plans did not sufficiently address the underlying issue. ▪ In general, individuals' work and day activities, and staffing needs were inadequately defined. ▪ 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. None of the 10 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, work was still needed to develop comprehensive ISPs. 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 10 ISPs (0%), action plans included adequate timeframes for completion. ▪ For none of the 10 ISPs (0%), the roles of the persons identified as responsible were clearly defined.	Noncompliance

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		This most recent review showed some improvement, and as noted above, it was clear that efforts were being made to improve the measurability of action plans. However, 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. ▪ Although some improvement was seen, the use of terms such as "as scheduled" or "ongoing" sometimes continued to be used as the timeframe for completion or frequency. These generally were not sufficient to make the objectives measurable and/or clearly define staff's responsibilities. ▪ In IHCPs, overall goals now sometimes included measurable indicators to allow measurement of an individual's status. However, the methods for measuring or the staff responsible for measuring them generally were not provided. The following was one example of an overall goal with multiple steps, and no delineation of how the outcome would be measured: "will be provided with correct positioning, clear environment, monitored for aspiration triggers, and provided with correct feedings, fluids, and medication regimen to maintain a patent airway AEB will have oxygen saturation greater than 95% room air over the next 12 months via growth records." It was not clear who was responsible for documenting in the growth records, or the frequency with which oxygen saturation rates would be measured, when this would occur, etc. ▪ Generally, direct support professionals were identified in the action plans as having responsibility for certain components of the plans. For example, when direct support professionals and supervisory or clinical staff were listed as both being responsible for the same action steps, definition was needed of for what the direct support professionals were specifically responsible as opposed to clinical staff. It will be important, though, 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 10 plans reviewed (0%) was the methodology sufficiently described for the action plans included. Some of the problems identified included: ▪ Although improvement continued to be seen in relation to the inclusion of the methodology, steps were often missing. For example, objectives such as: "will continue to attend Kaleidoscope class," "will continue to attend community outings," "environmental sweeps," "Teaching of danger of MRSA, SIB activity," or "random J-tube feeding pump checks" did not set forth the expectations with regard to what these activities would entail. ▪ As noted above, sometimes methodology was included in the IRRFs for	

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		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 the roles of various team members should be specified.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	All plans included some practical and functional interventions. In fact, the vast majority of skill acquisition plans identified functional skills to be taught. 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 bus, use of the public library, shopping in the grocery store for healthy items, cooking in cooking class, exercising, using an adaptive switch to turn on and off the radio, washing hands, budgeting, making a bed, etc. However, none of the 10 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. A couple of the plans reviewed included a goal related to cooking, but these goals were implemented in a cooking class. One of the plans reviewed included a goal related to bed making, but generally, the plans did not include 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	Noncompliance

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		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). However, as noted elsewhere, with the revised monthly review policy, teams were required to review attendance issues should certain criteria be met. 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 data collection, and the person(s) responsible for the data review.	Based on the review of the sample of ISPs: ▪ Although some improvements were seen with regard to teams' use of data, none of the 10 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. In reviewing ISPs or observing ISP meetings, often the action steps in the IHCPs identified the frequency of data collection, but not how frequently the person responsible for reviewing progress and efficacy would review the data. This varied, but 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." As a couple of examples: ▪ For Individual #9, an action step read: "Nursing will check for residuals before every feeding and [medication] administration." Nursing was listed as responsible for implementation, and the monitoring frequency and location of documentation was daily/medication administration record (MAR). This made sense, but then the person responsible for review of progress and efficacy was listed as the Nurse Case Manager. No frequency of review was provided. It was unclear if the frequency in the "monitoring frequency" column was to be used, and if so, then the Nurse Case Manager would be expected to review this daily. ▪ 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 of review. For example, at the ISP meeting for Individual #70, the IHCPs were not specifically discussed, so the team did not review and modify drafts, or work out the details of the data that would be collected, and who would be responsible for its collection and review.	Noncompliance

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		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 therapy plans, BSPs, psychiatric treatment plans, restraint reduction plans, etc.). As a result, appropriate data was not identified to assist teams in decision-making, and existing plans were not effectively incorporated into the overall ISP planning and implementation process. 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 being made 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 continued 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; 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 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	DADS Policy #004.1 at I.C.22 required the ISP to be accessible and comprehensible to 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	Noncompliance

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	responsible for implementing it.	easily available. Copies of the ISPs as well as the skill acquisition programs also were accessible to staff in Individual Notebooks. The Lead QIDPs were responsible for checking a sample of 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 10 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). Due to the more extensive clinical information in the ISPs, in an effort to assist the direct support professionals to identify their specific responsibilities, a new process was being instituted. It involved the development of Direct Support Professional Instructions. The Monitoring Team looks forward to reviewing these during upcoming reviews. In addition, training responsibilities had been delineated for the various components of the ISPs. For example, QIDPs were responsible for training direct support professionals on the ISP action plans, with a focus on what their specific responsibilities were. The RN Case Manager would be responsible for training on the Direct Support Professional Instructions. Education and Training staff provided training on the skill acquisition programs, and the various disciplines were responsible for training on plans such as PNMPs and BSPs. Tracking systems were in place for some, but not all of these training requirements. The Facility remained out of compliance with this provision. Additional work was needed to ensure various staff's responsibilities were clearly delineated in easily	

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		understood terminology, and training was completed on the various components of the ISPs.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	DADS Policy #004 at III.A addressed individual support plan monitoring. This included the requirements of the Settlement Agreement for monthly reviews and action, as appropriate. It required that within 10 calendar days after the end of the review period, the monthly reports would be filed in the individual's record. Since the last review, the CCSSLC Policy F.10 – ISP Monitoring/Monthly Review Process had been revised with an implementation date of 5/2/13. Additions were made with regard to monitoring individuals' attendance for class and work. Parameters were set for when the teams needed to take action related to attendance issues, and the types of actions teams needed to take depending on the cause of the attendance issues. In addition, as discussed with regard to Section F.1.a, in May 2013, the Programming Review Committee began meeting. Facility staff reported that they had recognized the need to improve monthly reviews, but a regulatory finding had further prompted the need to develop this committee. The group met weekly and reviewed two individuals' ISPs and monthly reviews. The individuals selected had had ISP meetings three months prior, allowing time for the QIDP to complete the ISP document and at least one monthly review. As noted above, leadership from the QIDP and Education and Training participated in the meetings, as well as the QIDPs and the staff responsible for the development of skill acquisition programs. The documents were provided ahead of time, and team members were expected to complete a monthly review assessment tool and come to the meeting with comments prepared. Based on observation during the week of the onsite review, this offered a respectful peer review opportunity for the monthly reviews and ISPs that should result in improvements in both. It was anticipated that next steps would be establishing inter-rater reliability with the tool, aggregating and analyzing data collected from this process, and identifying and acting on any problematic trends. Based on a review of the sample of ISPs: ▪ Based on the sample of 10 records, six (60%) had timely monthly reviews each month for the previous three months. Those that did not included Individual #269, Individual #353, Individual #290, and Individual #46. ▪ 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 QIDPs' review of skill acquisition programs, ISP action plans, and some brief updates on specific topics (e.g., incidents and allegations, hospitalizations, peer-to-peer incidents, etc.). Although QIDPs were required to	Noncompliance

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		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." At the QS/QI Council meeting that the Monitoring Team observed, the QIDP Coordinator identified this as one of the areas in need of improvement. ▪ For three individuals (i.e., Individual # 353, Individual #290, and Individual #61), a lack of expected progress or change in recommended supports was noted requiring action. In one of these instances (33%), adequate action was documented (i.e., Individual #61). 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. As noted in the last report, CCSSLC had begun to use a format of the monthly review that included graphs illustrating the data. All of the monthly reviews included in the sample used the graphs. The graphs improved the information included in the reports, and in some instances, the narrative summaries had begun to provide a description/analysis of the data, so it is clear to the reader what the data meant (i.e., was the individual progressing). Given that the ISPs generally did not include the specific SAP language, it will be important for the narratives to identify the actual skill being taught. As one of many examples, Individual #97 had the following action step in her ISP: "will improve her exercising skills by demonstrating task analysis steps 1-4 for 3 out of 4 weekly trial per month for 3 consecutive months." Data was provided without any indication what the skills being taught were, or what level of prompting was required. 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 integrating skill acquisition data into the QIDPs' monthly review, the Facility did not yet have an 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.	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. The QIDP Educator was seeking certification on the Supporting Visions curriculum, and once that	Noncompliance

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	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.	was obtained, she would be able to assist with this training. ▪ In August 2013, all IDTs participated in training on the At-Risk process that CCSSLC had developed. This training is discussed above, as well as with regard to Section I. It incorporated information about the general ISP process, as well as in-depth information about the IRRF and IHCPs. As noted above, it provided a good structure for teams to use when developing action plans. ▪ As noted in the last report, the QIDP 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?" At the time of the most recent review, it was still awaiting production through the I-Learn process to make it available electronically. The target audience was all direct support professionals. Comments on the content were provided in the last report. ▪ The QIDP Coordinator had developed a Job-Specific Training Schedule, and the QIDP Educator was implementing it with new QIDPs. It identified the QIDP responsibilities, as well as essential job functions, and set forth a structure for documenting that new QIDPs 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 QIDPs were familiar with their many duties had been developed and was being implemented for new QIDPs. ▪ The Q Construction: Facilitating for Success training was still provided to new QIDPs. 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 QIDP Coordinator also continued to provide training to QIDPs as CCSSLC policies or procedures changed. ▪ In June 2013, the QIDP Coordinator provided training to IDTs on each of the Units. Scenarios were used to prompt discussion from the teams about writing ISPAs, including related action plans. This was an innovative approach to try to expand teams' skills in this area. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QIDPs 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. In addition,	

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		the monitoring checklist included some indicators that could be used to assess QIDPs' facilitation skills as well as their skills in finalizing the ISP document. At the time of the last review, none of the QIDPs had been deemed competent in meeting facilitation or the development of ISPs. Since then, the QIDP Educator and two QIDPs had been deemed competent. One of these QIDPs had since left the Department. A total of 12 QIDPs and two Lead QIDPs still needed to achieve competence on facilitation. None of the QIDPs had yet been deemed competent with regard to finalizing the ISP document. ▪ Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. ▪ As Facility staff recognized, even though some training on the development of action plans had been provided, more likely was needed. ▪ 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." Based on interview, this was an area still under development. As noted in relation to Section F.2.c, training responsibilities had been delineated for the various components of the ISPs, and some training was occurring. However, work was still needed to ensure all staff had achieved competence on the implementation of specific ISPs. Progress was being made on training staff, but the Facility remained out of compliance with this provision. In addition to focusing efforts to provide additional training and technical assistance to improve the team process during team meetings, QIDPs' 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	Based on data the Facility provided, between February 2013 and July 2013, six individuals had been admitted to the Facility. All six individuals' 30-day ISP meetings (100%) had been held within 30 days of their admission. Based on data the Facility provided, 241 ISP meetings were held between 8/1/12 and 7/31/13. All annual ISP meetings occurred within 365 days of the previous annual meeting. The Facility tracked the dates that ISPs were completed and filed. Within this time period, of the 241 meetings held, 83 (34%) plans were completed and filed within 30 days of the ISP meeting date. The Facility also indicated that 11 ISPs were completed within 30 days, but no filing date was available.	Noncompliance

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	written extension.	The Facility had developed a tracking system to determine which ISPs were filed late versus which ones were completed late. For example, in the Presentation Book, the Facility provided data for ISPs completed in June 2013. It showed that 21 meetings were held. QIDPs had finalized 10 of these documents within 30 days (48%). Seven of the completed ISPs also had been filed within 30 days of the ISP meeting (33% of the total ISPs for the month). As is noted in other sections of this report, IDTs did not consistently make changes to 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. ▪ As noted in the last report, 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 had continued to revise its monitoring/audit tools for Section F. At the time of the review, CCSSLC was using a revised version of the Individual Support Plan Meeting and Documentation Monitoring Checklist. This audit tool focused on pre-meeting activities, and the ISP meeting. CCSSLC also was using the Individual Support Plan audit tool, which focused on the ISP document. As discussed in further detail in the Self-Assessment section, it was positive that staff had developed guidelines for the audit tools. However, as discussed in previous reports, additional work was needed to ensure the quality of ISPs meetings and ISP documents were reviewed. ▪ A Program Compliance Monitor from the QA Department, as well as the QIDP Coordinator were conducting the reviews. At the time of the review, the QIDP	Noncompliance

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		Coordinator was conducting four audits a month, and the PCM was conducting two per month. ▪ 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. ▪ As noted previously, in response to a regulatory review finding, the Facility had implemented a Corrective Action Plan for Section F. It related to the need to improve monthly reviews, and resulted in the development and implementation of the Programming Review Committee. It appeared to be providing a good peer review system for ISPs and monthly reviews, but it was still too early to measure its impact. 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., QIDP Coordinator) responsible for conducting audits. Facility staff were actively working on this piece. As noted in previous reports, the PCM and QIDP Coordinator had been holding consensus meetings to discuss monitoring results. Based on interview with staff, they had been looking more at their methodologies. The continued refinement 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). ▪ During the Monitoring Team's onsite review, the QIDP Coordinator presented at the QA/QI Council on Section F. Based on this presentation, as well as review of presentations from previous QA/QI Council meetings, a number of important areas of need had been identified. This was an important first step in an effective quality assurance system. The next step was development and implementation of concrete plans to address the outstanding areas. Section F requires the involvement of all disciplines, and this would be an area where a systemic CAP might be useful to tackle some of the more difficult issues, such as the quality of assessments, integration of supports and services, development of quality actions plans, etc. This was an area requiring further work. It was positive that the Facility was continuing to work on developing meaningful audit tools with guidelines, and that the QIDP and QA Departments were meeting regularly to review results. 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.	

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 morning medical meeting minutes, copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed for following dates: 9/23/13 to 9/27/13; o For hospitalizations in prior six months, copies of follow-up Individual Support Plan Addendum; o For one individual from each residential home, copies of all consultant reports (medicine and surgery inclusive of subspecialties) since the Monitoring Team's last visit and all integrated progress notes (IPNs) commenting on consultant reports (medicine and surgery inclusive of subspecialties) (agreeing or reason not agreeing) and any ISP addendum related to the consultant report: Individual #172 podiatry consult; Individual #310 urology consult; Individual #169 ophthalmology consult; Individual #338 dermatology consult; Individual #338 Ear, Nose, and Throat (ENT) consult; Individual #338 ophthalmology consult; Individual #150 ophthalmology consult; Individual #150 hematology consult 3/28/13; Individual #150 hematology consult 5/6/13; Individual #282 cardiac consult; Individual #282 urology consult; Individual #283 gastroenterology consult; Individual #276 dermatology consult 3/12/13; Individual #276 podiatry consult 2/20/13; Individual #276 nephrology consult; Individual #276 ophthalmology consult; Individual #276 dermatology consult 7/9/13; Individual #276 podiatry consult 7/17/13; Individual #181 urology consult 5/8/13; Individual #181 urology consult 8/5/13; Individual #44 cardiac consult; Individual #44 ophthalmology consult; Individual #44 retinal specialist; Individual #90 ENT consult 6/11/13; Individual #90 ENT consult 6/25/13; Individual #90 ENT consult 7/9/13; Individual #229 ENT consult 6/12/13, and Individual #229 ENT consult 7/15/13; and o Guidelines for new "Section G Monitoring Tool." ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD, PhD, MBA, Medical Director; and o Greg Walker, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section G, 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 tool the Facility used to conduct its self-assessment included: Section G Monitoring Tool, Individual Support Plan/Individual Support Plan Addendum (ISP/ISPA) follow-up to consultant recommendations monthly audits, and monitoring of open record reviews for specific diagnoses (e.g., aspiration pneumonia, sepsis, recurrent pneumonia, reactive airway disease, and respiratory failure).

	○ The monitoring/audit tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement concerning follow-up of consult recommendations. The audit tool specific to Section G.2 appeared helpful in providing quality information. The monitoring tools for Section G.1 included documentation aspects of the processes audited, but did not include monitoring of quality issues. The Facility is encouraged to review the Monitoring Team's report to identify other indicators that are relevant to making compliance determinations for Section G.1. ○ The monitoring tools included methodologies such as conducting record reviews, and reviewing consult recommendations. These were sufficient for review of documentation of specific steps completed. Development of criteria to assess quality needed focused attention, such as development of standards to determine the quality of the open record reviews and the post-hospital ISPAs. ○ 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 not always adequate to consider them representative samples (e.g., sample size for attendance at meetings). Sampling methodology (i.e., random, etc.) was not clarified for each of the monitoring tools. ○ The Section G.2 monitoring tool had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. Instructions for monitoring of the audits for Section G.1 were not provided. ○ The following staff/positions were responsible for completing the audit tools: the Medical Compliance Nurse. ○ The staff responsible for conducting the audits/monitoring had clinical experience in the relevant area(s). The Facility did not have processes in place to ensure that staff that completed monitoring were competent as monitors. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. This included attendance at the integrated clinical services meetings each weekday morning, as well as attendance at other clinical interdisciplinary meetings. ▪ The quality of the data maintained in the databases was variably complete or incomplete. Databases considered complete included attendance rosters. Examples of databases/data sources that were not considered complete included the many areas needing closure at the Integrated Clinical Services Team meeting. There was little information concerning a monthly total of completed open record reviews versus outstanding ones, ISPA reviews, ISPA agreement/approval by the morning meeting attendees, and follow-up of closure concerns (with date of closure and outcome). In some cases, additional mechanisms were needed to capture this information. From the ICST meeting handouts, templates concerning monthly totals of these activities remained blank. ▪ When data was provided, the Facility sometimes presented data in a meaningful/useful way, but some concerns were noted. Specifically: ○ The Facility's Self-Assessment utilized a table format in providing data, which could be

compared month-to-month for the data available.
    - Findings consistently were presented based on specific, measurable indicators.
    - The Facility did not consistently measure the quality as well as presence of items. This is an area needing improvement.
- The Facility rated itself as being in noncompliance with Section G. This was consistent with the Monitoring Team's findings.
- The Facility data identified areas of in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information, identifying for example, the need to monitor completion of open record reviews, and continued monitoring of attendance.

Summary of Monitor's Assessment: The Integrated Clinical Services Team meeting developed a structure for presenting various clinical services. With this structure in place, further development of the full potential of this process was possible. Attendance was measured, and included representation by several departments. However, better time management will be important in order to include discussions of prevention of hospitalization and Emergency Room visits, as well as review of open record reviews and ISPAs. In order to make findings available for the ISPA process, timely completion of the open record review will need focused attention and monitoring. ISPAs appeared to be completed late for many post-hospital reviews. Many of the ISPAs did not address preventive steps, and the ICST meeting should review and return these to the Interdisciplinary Team for further documentation of preventive steps.

Tracking of the consultant recommendations and follow through by the Primary Care Practitioner appeared to be thorough and accurate, but standards for when IDTs needed to review the consults and consider further action were needed.

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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 9/23/13 to 9/27/13. Specific staff and departments were tracked for percentage attendance. The following was obtained from the submitted information for this time period:	Noncompliance

Department	Number of days attended
Nursing administration	0
Hospital liaison	2
Habilitation therapies	0
QIDP	0
Dietary	0
Chaplain	0
Psychology	5
Dental	5
Incident Management	0

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Medical Compliance RN	5
Infirmary	4
Infection control	3
Physical and Nutritional Management Team (PNMT)	0
Residential	0
QA/QI	1
Pharmacy	5
Psychiatry	4
Medical	5
RN Case Manager	5

No policy was provided indicating which departments were required to attend the morning medical meeting. If such a policy does not exist, it is recommended a policy be created to provide guidance to those departments with required daily attendance and the departments expected to provide reports at intervals.

The following information summarizes the contents of the morning medical meeting minutes for the week of 9/23/13 through 9/27/13, the week prior to the Monitoring Team's visit:

- The number of meeting minutes totaled two of five (40%).
- Zero of five (0%) meetings recorded attendance. Attendance was separately requested and obtained.
- Five of five (100%) morning medical meetings included review of the Campus Coordinator Log. The handout provided determined this. There were no minutes for three of the days to confirm discussion of the Campus Coordinator Log.
- Five of five (100%) morning medical meetings included review of the on-call provider report. The handout provided determined this. There were no minutes for three of the days to confirm discussion of the on-call provider report.
- Four of five morning medical meetings included a report by the Hospital Liaison Nurse. An additional one of five included a review of hospitalizations. In summary, hospitalizations were reviewed in five of five (100%) days.
- Zero of five (0%) morning medical meetings included discussion of measures to prevent another hospitalization/ER visit for individuals hospitalized or using the ER.
- Zero of five (0%) morning medical meetings included the appointment/ assignment of a member of the morning meeting to review the open record for seven or more days prior to the hospitalization/ER visit.
- Five of five (100%) morning medical meetings included a discussion concerning Infirmary admissions. The Infirmary census for the week ranged from nine to 11

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		admissions. ▪ One of five (20%) morning medical meetings included discussion of results of an open record review. There were two open record reviews. ▪ Four of five (80%) morning medical meetings included additional information provided through a Medical Director/Medical Compliance Nurse announcement. A total of four announcements were documented. ▪ Zero of five (0%) morning medical meetings included discussion and resolution of closure items. ▪ One of five (20%) morning medical meetings included a review of one ISPA as part of the closure process at the medical morning meeting. ▪ One of one (100%) ISPAs was approved by the medical morning meeting as addressing the concern directed to the IDT. ▪ Zero of one ISPA were returned to the IDT for further review to address the concern. ▪ Five of five (100%) morning medical meetings included a review of consult reports. A total of 17 consults were reported or updates provided as to status of the consultation. ▪ Zero of five morning medical meetings recorded a PNMT report. ▪ One of five morning medical meetings included information provided by the Dental Department. ▪ Zero of five morning medical meetings included an update by the infection control nurse. ▪ Zero of five morning medical meetings included updates concerning individuals having medical/dental restraints. ▪ Zero of five morning medical meetings included a skin integrity report. ▪ Zero of five morning medical meetings included a discussion or report of any individuals with significant weight gain or loss. ▪ One of five morning medical meetings included a discussion/in-service of systemic medical concerns, policies or procedures, quarterly analyses of data, etc. From additional documents submitted, it was noted that other departmental reports would be presented at these morning medical meetings. Recorded in the 3/25/13 Infection Control Committee meeting minutes, documentation indicated that a list of needed vaccinations for each month would be provided at monthly intervals at the morning provider meeting. The Facility submitted ISPAs generated for hospitalizations that occurred during the six months prior to the Monitoring Team's visit. Submitted were documents for post-hospitalization ISPAs/IHCPs involving 30 individuals for 36 hospitalizations. These were reviewed to determine the reason for hospitalization, evidence of a record review for	

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		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. ▪ Of the 30 individuals, zero individuals were hospitalized for concerns that did not apply to these measures and were excluded (i.e., planned surgery, etc.). ▪ Several individuals had more than one hospitalization, and measurements did not separate out the various admissions per individual, but all documentation 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 needed additional action steps/processes as part of the IDT review. However, the IDT did demonstrate one or more processes in a number of cases. The findings included the following: o Reference to a record review/open record review was documented in four of 36 hospitalizations (11%). o The IDT identified new triggers or early signs/symptoms following two of 36 hospitalizations. o The IDT identified the need for increased monitoring in one or more aspects of care following 11 of 36 hospitalizations. o The IDT identified specific additional/new preventive steps to be implemented to reduce the recurrence of the cause of the hospitalization in 15 of 36 hospitalizations. o The time from discharge from the hospitalization to the creation of the initial ISPA was within five days in nine of 36 post-hospital ISPAs submitted. The documents did not supply the needed information (i.e., hospital discharge date, ISPA date, etc.) in eight of 36 hospitalizations to assess timely completion of the post hospital ISPA. The Medical Department submitted documentation of closure to issues identified at morning medical meetings for up to 60 days prior to the Monitoring Team's visit. Nine ISPAs were submitted for 11 events. Two individuals had a repeat event similar to the first before the ISPA was created for the first event. An ISPA was not created for the first event separately, although the time between events was eight days for one individual and five days for the other. The time from the assignment of the ISPA by the morning medical meeting to the completion of the ISPA varied from three to 23 days, with two events having no timely ISPA completed prior to a repeat event. Based on an expectation that completion of a quality ISPA addressing the urgent needs of the individual should occur within five days, two of the 11 (18%) events met the timeliness criteria.	

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		The ISPAs were reviewed for content to determine if adequate preventive steps were implemented based on the needs of the individual. Three of the submitted nine ISPAs (33%) had sufficient preventive action steps in place. ▪ One individual swallowed razor blades from a pencil sharpener, and then 26 days later swallowed a pull-tab from a soda can. The team had delays in creating an ISPA to respond to the urgent need, 23 days from the first event and 11 days from the second event. There was no discussion of environmental sweeps or frequency, only removing a pencil sharpener from the environment. No other departments were identified to potentially assist in monitoring to ensure the environment was safe. There was mention of counseling, but the action step was vague. Further discussion about anger management would have provided more focus. ▪ Another individual swallowed brake fluid, but the response was to remind staff to lock their car doors. The response appeared informal and vague. A formal policy, along with monitoring of the parking lot by QA or other departments to check on doors would have provided needed assurance of a safe environment. Guidance of where to park cars if door locks did not work, or if staff preferred to leave car windows open was not addressed. Although the initial concept was helpful, there was no evidence of concrete steps to ensure a safe environment. ▪ One individual had two hospitalizations for swallowing glass before the IDT completed an ISPA. However, it needed further review to ensure safety. There was no mention of environmental sweeps in the residence and environmental checks outside the residence to remove glass shards. The frequency of sweeps and inspections, and the staff assigned this task, was not addressed. The residence appeared not ready to accept the individual back the first time, because no ISPA had been created at that point, and the individual promptly swallowed more glass the same day as arriving back. There was no discussion of whether one-to-one Level of Supervision (LOS) was sufficient, or a description of additional steps to block the individual as the steps in place to date had not been effective. There was no discussion of a record review to determine any premonitory mood swing signs or symptoms, which might forecast the urge to defy the increased level of supervision. ▪ Another individual had passed a vinyl glove and coins without staff awareness. LOS was increased, but there was not a discussion of environmental sweeps to ensure gloves and coins were not readily available. The was a need to review how gloves were stocked in living areas, how accessible they were to individuals, and how and where used gloves were disposed and whether this was a potential source for the individual obtaining gloves for ingestion. A record review was not completed which might have identified early warning signs. It was concerning that the morning medical meeting accepted these ISPAs and did not	

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		return them to the IDT for further review. The Medical Department tracked three additional closure items. ISPAs were not created, but emails provided the closure information. Timeliness was found in one of three (33%). One IDT response was documented 81 days after the assignment of the concern to the IDT. The other delayed response was documented through an email, which occurred 23 days after the morning provider meeting participants assigned follow-up to the IDT. In summary, from both the ISPA follow-ups and email/other communication follow-ups, there appeared to be delays from the IDTs. The IDT process, in responding to the medical concerns identified by the morning medical meeting, requires a written ISPA back to the morning medical meeting within five days. Due date assignments should not extend beyond this time period unless reasons are provided. The morning medical documentation listed a number of assigned open record reviews that had not been closed. Several were past the due date. It was not determined whether the review had not been completed in a timely manner, whether the review had been completed and had not been presented, or whether the morning medical meeting had insufficient time to address the review. It was noted that ISPAs were completed after individuals' discharges from the Infirmary. A review should occur of the timeline for assignment of the open record review when individuals are hospitalized or admitted to the Infirmary from the residence. If the reviews were assigned and conducted earlier, then the open record review results could assist the team in discussing how to prevent a recurrence, and any findings could be addressed in the ISPA. The open record review should be available when the IDT meets to create an ISPA. The open record review would be most valuable to the IDT as they meet to create the ISPA in preparation for discharge from the Infirmary to the residence. The open record review should be completed prior to the IDT meeting, as members then have the opportunity to review findings applicable in creating the ISPA. Additionally, It is essential the open record reviews be completed by the due date determined at the integrated clinical services meeting and presented in a timely manner to the morning meeting participants, because this discussion should occur prior to making the results available to the IDT for inclusion in the ISPA. Attendance at ISPs was one measurement of integrated clinical services. Information was derived from the self-assessment documents, and was not confirmed by separately submitted evidence. However, the following provides information about attendance for several clinical departments per month:	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Department</th><th>February 2013</th><th>March 2013</th><th>April 2013</th><th>May 2013</th><th>June 2013</th><th>July 2013</th></tr>
<tr><td>Number of ISPs per month</td><td>5</td><td>6</td><td>5</td><td>6</td><td>5</td><td>4</td></tr>
<tr><td>PCP</td><td>40%</td><td>33%</td><td>80%</td><td>17%</td><td>40%</td><td>50%</td></tr>
<tr><td>Dental</td><td>67%</td><td>50%</td><td>100%</td><td>75%</td><td>75%</td><td>NA</td></tr>
<tr><td>Pharmacy</td><td>NA</td><td>NA</td><td>NA</td><td>0%</td><td>NA</td><td>NA</td></tr>
<tr><td>Psychiatry</td><td>NA</td><td>NA</td><td>NA</td><td>0%</td><td>NA</td><td>100%</td></tr>
<tr><td>Nursing</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Occupational Therapy (OT)</td><td>0%</td><td>67%</td><td>100%</td><td>0%</td><td>0%</td><td>50%</td></tr>
<tr><td>Physical Therapy (PT)</td><td>0%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>50%</td></tr>
<tr><td>Speech</td><td>0%</td><td>60%</td><td>100%</td><td>100%</td><td>0%</td><td>0%</td></tr>
<tr><td>Psychology</td><td>100%</td><td>33%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Dietary</td><td>0%</td><td>NA</td><td>NA</td><td>NA</td><td>0%</td><td>NA</td></tr>
</table>

This chart was problematic as evidence, because it only indicated a few of the ISPs. For Section H, submitted information indicated there were several more ISPs per month. Given the census at CCSSLC, the number of ISPs sampled per month would need to be greater than the number provided here. However, if this was a sample of attended ISPs (through the QA Department monitoring process or internal Medical Department monitoring, for example), it was not indicated on the chart provided. How ISPs were chosen for the sample size also was not shown. Attendance is most accurately derived from 100 percent of applicable meetings. This information did not provide the needed evidence to determine percentage attendance at ISPs.

The Facility remained out of compliance with this subsection.</td><td></td></tr>
<tr><td>G2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.</td><td>The Facility submitted consultant reports for one individual from each residence, as well as any IPNs and ISPAs commenting on the consultant reports. Consultations for 12 individuals were submitted, with a range of one to five consultations per individual. A total of 28 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following:
▪ Of the 28 reviewed, 25 (89%) included the PCP initials, indicating review by the PCP.
▪ Of the 28 reviewed, 25 (89%) 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.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		o Of the 28 reviewed, 27 (96%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of these, 24 (86%) included PCP IPN entries. ▪ Of these, there was evidence that the IDT was informed of the consultation results in 27 (96%). ▪ Of these, eight ISPAs documented the discussion of the contents of the consultant reports, and the PCP's recommendation. There were five consultations for which follow-up ISPAs were indicated but in which no ISPA was documented. It is recommended that the Facility provide guidance in determining criteria for which an ISPA is indicated for a medical/dental consultation. The eight for which an ISPA was created reviewed changes in medication, tests to be ordered, and/or follow-up appointments. Based on these criteria, ISPAs were needed for all 28 consultations. However, there were five consultations that required implementation of training for direct support professional (DSP)/nursing for signs and symptoms, followed by increased monitoring and documentation of monitoring; need for appropriate discussion in completing a missed appointment due to inability to cooperate; or follow-up to ensure how the team was to comply with the consultant's recommendations in the residence. Zero of five (0%) had an ISPA submitted for these individuals. There did not appear to be consistency as to when an ISPA was developed and when it was not developed. An internal audit process was created for this section. The document was entitled "Section G Monitoring Tools," and it addressed Section G.2 of the Settlement Agreement. It required record review of the recommendations from non-facility clinicians to determine whether there was appropriate and complete documentation concerning follow-up to these recommendations and referral to the IDT when indicated. A series of seven steps was defined and measured for this process. Training of the Medical Compliance Nurse occurred on 6/3/2013, at which time it was implemented. There were "Guidelines for using the New Section G Monitoring Tools," which allowed consistent documentation during the audits. The Medical Department utilized this tool to retrospectively review consults dating from February 2013, and internal data was provided indicating data was current through July 2013. This tool reviewed a sample of consultations for each of six measurable indicators, including: 1) PCP reviews, signs, and dates recommendations from non-facility clinicians; 2) PCP Integrated Progress Notes documentation of agreement/disagreement written within five days; 3) PCP orders	

#	Provision	Assessment of Status	Compliance
		written for accepted recommendations; 4) Evidence that IDT was informed of PCP's review of recommendations; 5) Consultant recommendations signed by appropriate IDT members; and 6) Recommendations are integrated into ISP/ISPA. Results were tracked for each of these areas to determine trends. The results did appear to capture the role of the PCP in processing the off-campus consultant recommendations. The monitoring tool appeared less effective in determining the quality of the ISPA in following through to complete the recommendation (i.e., staff training, etc.).	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H; and o Four most recently completed annual medical evaluations/assessments of individuals from each PCP's caseload, copy of the active problem list, with identification of four significant diagnoses, and criteria/evidence justifying each of these four diagnoses. ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD, PhD, MBA, Medical Director; and o Greg Walker, RN, Medical Program Compliance Nurse.
	Facility Self-Assessment: For Section H, 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: record audit to determine criteria for major diagnoses, internal and external medical management audits for six diagnoses, and Medical Department internal quality indicator tools. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with specific aspects of 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, including quality content of post-hospital ISPAs. o The monitoring tools included adequate methodologies, such as record reviews. o 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. o The submitted monitoring/audit tools did not include instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Medical Compliance Nurse. o The staff responsible for conducting the audits/monitoring had clinical experience in the relevant area(s). The Facility did not have processes in place to ensure that staff that completed monitoring were competent as monitors. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, including, for example: timeliness of completion of annual assessments prior to the ISP and timeliness of completion of post-hospital ISPAs. However, the data maintained in some of the databases was not in agreement with data provided in other

	databases. Inconsistencies between databases were problematic. ▪ The Facility presented data in some meaningful/useful ways, but some problems were noted. Specifically: o The Facility's Self-Assessment included internal Medical Department quality reviews at periodic intervals for several diagnoses. These were presented in table format. o This section of the Self-Assessment presented findings consistently based on specific, measurable indicators. o The Facility did not consistently measure the quality as well as presence of items. ▪ The Facility rated itself as being in compliance with Section H.2. This was consistent with the Monitoring Team's findings. The Facility rated itself as being in noncompliance with subsections H.1, H.3, H.4, H.5, H.6, and H.7. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement, including the essential elements and nonessential elements of the medical peer review audits. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example, specific clinical indicators needing further review.
	Summary of Monitor's Assessment: The Medical Department identified that timely annual medical assessment and quarterly medical review completion needed continued focus. Dental assessments were completed timely. Timely completion of other discipline assessments for the ISP process had different data sets with different findings. The sample of active records included sufficient criteria for justification of the major medical and psychiatric diagnoses in the record. The Medical Department followed the corrective action plans for the medical management audit. The internal quality indicators the Medical Department used for monitoring provided evidence of significant advancement in this area. Several diagnoses were included, and baseline and serial results were provided. The analysis of results was not clear at times. For those questions on the audit reaching 100 percent repeatedly, there was no information concerning substituting other clinical indicators to continue to challenge the system. Section H.2 was found to be in substantial compliance. The other areas remained in noncompliance.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to	Several routine and periodic assessments for several clinical departments were reviewed for timeliness in submitted documents. These included: ▪ Based on data the Facility provided, 190 of 246 (77%) medical annual assessments were completed in a timely manner. For 20 most recent medical annual assessments, completion within 365 days of the prior assessment occurred in 15 of 20 (75%). A review of 10 active records indicated that a	Noncompliance

#	Provision	Assessment of Status	Compliance
	developments or changes in an individual's status to ensure the timely detection of individuals' needs.	medical annual assessment had been completed in the last 365 days in 10 of 10 (100%). ▪ One hundred sixty seven of 168 (99%) dental annual evaluations were completed in a timely manner. ▪ During the time period April through July 2013, based on data the Facility provided, 310 of 326 (95%) Quarterly Drug Regimen Reviews (QDRRs) were completed in a timely manner, although a smaller sample indicated less compliance in this area. Departments were required to submit completed annual assessments 10 days prior to the ISP meeting date. Two sources of information were utilized for this data. As the data was different from each source, each is listed. From the Presentation Book for Section G, the Self-Assessment indicated the following was part of the QA/QI Council minutes for the prior six months, in which the timeliness of annual assessments was recorded for various clinical departments:	

Department	February 2013	March 2013	April 2013	May 2013	June 2013	July 2013
Number of ISPs completed	22	23	20	23	21	20
Dental	100%	98%	100%	100%	100%	100%
Medical	89%	55%	79%	35%	43%	63%
Pharmacy	96%	89%	91%	100%	100%	100%
Psychiatry	0%	5%	6%%	44%	29%	89%
Nursing	85%	83%	91%	89%	955	97%
OT/PT	80%	79%	93%	86%	80%	54%
Speech	93%	89%	95%	87%	95%	75%
Psychology	65%	70%	79%	78%	97%	55%
Dietary	72%	89%	100%	90%	97%	75%

From documents submitted for Section Q, the untitled submitted document included the percentage of assessments submitted on time, based on the number of departmental assessments required for the ISP. Not each ISP required an assessment from the department.

Department	February 2013	March 2013	April 2013	May 2013	June 2013	July 2013
Number of ISPs completed	22	24	23	23	21	23
Dental	100%	100%	100%	96%	100%	96%

#	Provision	Assessment of Status	Compliance

Medical	59%	42%	61%	35%	67%	26%
Pharmacy	91%	87%	91%	91%	100%	96%
Psychiatry	0%	0%	8%	7%	8%	100%
Nursing	86%	96%	87%	74%	86%	83%
OT/PT	81%	75%	70%	86%	62%	52%
Speech	95%	87%	87%	78%	76%	78%
Psychology	64%	71%	61%	61%	71%	61%
Dietary	77%	79%	91%	87%	100%	78%

For some departments, the percentages were similar across the months for the two documents submitted. For other departments, such as medical, the differences were significant. It is recommended that the Facility review the database(s) and reports for this information to ensure consistency of results.

Additionally, another document was submitted entitled "Assessment Filing – number of times filed later than 10 days for meetings between the dates of 2/1/2013 and 7/31/2013." This listed the number of late assessments per department for that six-month time period. For the Medical Department, this chart indicated that only three annual assessments were submitted later than the due date. It was difficult to track progress in this area, especially with the Medical Department, given this conflicting information. However, the Facility remained in noncompliance with this subsection.

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 diagnoses submitted (97%), the criteria listed were consistent with the diagnosis listed. It was noted that the Medical Department completed an internal audit of records from February through July 2013, utilizing a sample size of 13 records (5%), to determine whether diagnoses were based on appropriate criteria. Results indicated that 100 percent of diagnoses were justified based on clinical evidence. The Monitoring Team's findings were consistent with the Medical Department findings. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed, there was adequate clinical justification for the diagnosis of record for 28 of the 28 individuals (100%). With the completion of Comprehensive Psychiatric Evaluations,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		annual Psychiatric Treatment Management Plans, and ongoing quarterly/monthly updates for everyone prescribed psychotropic medication, the Facility had solidified its diagnostic practices related to psychiatric disorders. Although not a requirement for compliance, the Facility submitted information that there were no in-services provided to the PCPs concerning International Classification of Diseases (ICD), and Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria in the prior six months. The Facility remained in substantial compliance with this provision.	
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.	As a measure of timely quality treatment/interventions, the Medical Department utilized the results of the external and internal medical management audit. In March 2013, an internal audit was completed for seizures, constipation, and urinary tract infections (UTIs). In June 2013, external and internal audits were completed for osteoporosis, diabetes mellitus, and pneumonia. Compliance per PCP ranged from 80 percent to 100 percent with the audit questions. It was noted that these audits generated 19 corrective action plans. Of these, 15 had closure within 30 days and four corrective action plans remained outstanding. The Medical Department had reviewed this information and was aware of the findings. More detailed information is discussed with regard to Sections L.2 and L.3. The Medical Department had created a number of additional quality medical care monitoring tools with specific measurable indicators. A copy of the tools was submitted. These tools were used monthly to audit a number of specific diagnoses or medical events for which treatment was provided at CCSSLC. The Medical Compliance Nurse completed an audit of a sample of records for each of these categories to create a baseline prior to April 2013, and then provided a monthly audit thereafter. The Medical Director reviewed and analyzed results to determine any trends. The topics included ER/Hospital visits, diabetes mellitus, osteoporosis, seizures, hypertension, and constipation. There were five clinical indicators reviewed for ER/Hospital visits, including: 1) An IPN explaining the transfer was present within 24 hours; 2) Provider summary was present within 24 hours of an ER/Hospital return; 3) Orders were written per ER/Hospital recommendations; 4) Appropriate consults were ordered, if needed or recommended; and 5) Follow-up lab and x-rays were performed within one week if needed. One to four records per month were audited for a total of eight records. Based on the Facility's data, compliance was 100 percent for all five indicators for May through July 2013. There were three clinical indicators for Seizures: 1) Consultation with a neurologist occurred at least every one to two years; 2) Anti-epileptic drug levels (e.g., Dilantin,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Tegretol, Depakote, Phenobarbital) were drawn every six months; and 3) There was periodic seizure review documentation at least yearly for those having active seizures. Baseline data was collected prior to the April 2013 audit. Audits were conducted in April 2013 and July 2013. Seven records were reviewed for the April 2013 audit, and nine records were reviewed for the July 2013 audit. Based on the Facility's data, compliance was 100 percent at the April 2013 audit, and 96 percent compliance at the July 2013 audit. There were seven clinical indicators for Diabetes Mellitus, including: 1) Hemoglobin A1C was performed at least twice a year; 2) Blood pressure was less than 135/90; 3) Urine microalbumin was performed annually; 4) Podiatry exam was performed annually; 5) Ophthalmology exam was performed annually; 6) A dietary consult was performed; and 7) An appropriate diet was ordered. Baseline data was obtained from November and December 2012. An audit was completed in May 2013 of three records. Outstanding concerns in the May 2013 audit included the following factors: urine microalbumin was performed yearly, and podiatry exam was performed yearly. Improvement was noted from the baseline for the following factors: podiatry exam was performed yearly, ophthalmology exam was performed yearly, and dietary consult was performed. There were six clinical indicators for Hypertension, including: 1) Blood pressures was less than 140/90; 2) A heart healthy diet was ordered; 3) Was there an obesity co-morbidity; 4) Was there a diabetes co-morbidity and if so was the blood pressure less than 135/90; 5) An annual lipid panel was present; and 6) An ophthalmology exam was performed every one to two years. Baseline data was collected in November and December 2012. A May 2013 audit was completed on eight records. Areas which presented challenges/areas needing improvement for the May 2013 audit included the following factors: blood pressure was less than 140/90, was there an obesity co-morbidity, and if there was a diabetes mellitus comorbidity, was the blood pressure less than 135/90? There were five clinical indicators scored for osteoporosis, including: 1) DEXA scan current; 2) Was patient immobile; 3) Medical management included a bisphosphonate (or Calcitonin), calcium and Vitamin D; 4) Most recent Vitamin D-25-OH was optimal; and 5) If supplementation was not needed is dietary intake adequate. Baseline data was collected in November 2012, and an audit was completed in June 2013 for six records. Areas identified as needing improvement were the following factors: DEXA scan current, was patient immobile, most recent Vitamin D-25-OH was optimal, and if supplementation was not needed, was dietary intake adequate? There were three clinical indicators scored for constipation, including: 1) Nutritional consult performed recommending amount of dietary fiber intake; 2) Fiber supplement	

#	Provision	Assessment of Status	Compliance
		ordered if needed; and 3) Medical management ordered. Baseline data was obtained, followed by record audits in April and July of 2013. Areas needing improvement were nutritional consult performed recommending amount of dietary fiber intake, and fiber supplement ordered if needed. There were five clinical indicators for Down syndrome, including: 1) Cervical radiographs have been taken within the past 10 years; 2) An echocardiogram has been performed; 3) Annual TSH and T4 were drawn; 4) Ophthalmology exam was performed every two to three years; and 5) Auditory testing was performed every one to two years. No baseline data was obtained. An audit of six records was completed in June 2013. An area needing improvement was cervical radiographs were taken within the past 10 years. These internal periodic reviews represent quality review of timely assessment/testing, treatment, and intervention. Several of these clinical indicators revealed areas needing improvement. The purpose of these audits was to identify these areas, to educate the PCPs on applicable corrective actions, and to repeat audits at intervals to demonstrate improvement. Next steps included an improvement in the findings with serial audits, and expansion of audit topics. The Facility had not fully implemented mechanisms to determine if the full range of treatments and interventions were timely and clinically appropriate. For example, as discussed with regard to Section M, Section I, and Section O, concerns continued to be noted with regard to the identification and provision of healthcare supports. Similarly, as discussed with regard to Section G.1, open record reviews were not consistently completed and/or the results utilized to identify necessary changes to care and treatment through the incorporation of information in ISPAs. The Medical Department was beginning to use protocols to measure quality of treatments, but this was in the initial phases. It will be important to use information gained from these processes to address any issues identified (e.g., corrective actions taken by the Medical Department based on the findings of these internal QA audits). 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.	For the monitoring tools listed with regard to Section H.3, the quality indicators relied on measurable responses or results [i.e., a specific diet was ordered (Y/N), a specific medication was ordered (Y/N), or physiologic parameters were stated (blood pressure) (Y/N)]. A few of them included clinical indicators of the efficacy of treatment (e.g., blood pressure readings, Vitamin D levels). It is recommended that these quality indicators be expanded to include lab values or other indicators of treatment efficacy as additional goals based on information provided from the clinical guidelines/pathways and national standards. Determining the normal range or threshold value or indications of	Noncompliance

#	Provision	Assessment of Status	Compliance
		improvement (e.g., for HgbA1C, improved T-scores, etc.), would provide evidence of "efficacy of treatment" or whether additional treatment or changes in medication were needed. Referencing the source of information in a footnote or in a policy that provided guidance in creating clinical indicators would ensure clinical justification of those goals/levels. Additionally, providing a system for constantly updating the clinical indicators as advances are made in medicine should be an ongoing aspect of QI monitoring. In addition, as discussed in previous reports, the individualized integrated health care plans (discussed with regard to Section I) should identify measurable objectives in achieving a clinical outcome. These measurable objectives could be tracked, and the clinical outcome or clinical indicator of health also could be followed to determine whether treatment is adequate, needs to be changed, or needs to be augmented in some way. This could occur at the individual level, but data also could be collected and analyzed on a more systemic level. The Facility was in the initial stages of identifying and implementing clinical indicators to assess the efficacy of treatments. CCSSLC remained out of compliance with this provision.	
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.	Two of 10 (20%) active medical records included current medical quarterly notes for the prior three quarters. Fourteen of 21 (67%) recent QDRRs were current. As is discussed in more detail with regard to Section M.1, challenges remained in the Nursing Department and in the residential services in identifying health status change at an early stage, and providing appropriate monitoring once a concern was identified. Along with serial departmental assessments, the ICST meeting each business day provided a review of acute health status changes for those individuals on campus as well as those hospitalized. This was done through the on-call PCP report, a review of the 24-hour log, the Infirmary admissions report, and the Hospital Liaison Nurse report. The handouts and minutes provided written documentation of review and discussion of each case. Open record reviews were to be completed on any individual hospitalized with "diagnoses of interest," which included pneumonias. At the time of the Monitoring Team's visit, this had not occurred for all such hospitalized individuals and continued to be a goal. Additionally, there were considerable delays in completing these assigned tasks, as well as delays in finding time in the morning report schedule to discuss the results of the reviews. A list of open record reviews not brought to the morning medical committee was listed with each day's handout. Further, delays in completing and	Noncompliance

#	Provision	Assessment of Status	Compliance
		reporting this information led to lack of communication with the IDT members as they prepared the ISPA. There appeared to be no system in which the open record review was completed before the ISPA process was initiated. It is recommended an open record review be completed as soon as a diagnosis is made at the hospital, in order to maximize the period of time before the individual is discharged and the ISPA process is begun. Although ISPAs generally were created following hospitalization (100% for the sample reviewed), there was a lack of timeliness in completion of the ISPA (as mentioned with regard to Section G.1) and a lack of quality content to ensure steps were taken to prevent a recurrence. Steps should be clearly written to indicate the preventive steps to be completed, including a timeline if applicable, for training of staff or obtaining equipment. The Facility remained in noncompliance 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.	For compliance with this subsection, on an individual basis, it will be important for the Facility to have a working system to clearly identify changes in status based on clinical indicators, and to show that IDTs responded appropriately to such changes. As discussed in more detail with regard to Section I, work had begun in this regard. In addition, as discussed with regard to Section H.4, the Medical Department's audit tools should include clinical indicators, focusing on the actual clinical values of tests and radiographic reports, etc., to determine whether the current treatment was adequate or needed to be changed (e.g., change dosage, add medication, remove medication, other therapies added, etc.). When change was indicated, the audit should measure whether there was evidence it occurred through PCP orders, and whether this was done in a timely manner, along with orders for further monitoring to determine improvement or lack of improvement, need for further consultation or need for further lab testing, scans, etc.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility indicated that integrated clinical services policies, procedures, and guidelines had not been developed or implemented.	Noncompliance

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 #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections; and 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 ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form past one year, and risk action plan past one year for: Individual #333, Individual #311, Individual #127, Individual #369, Individual #113, Individual #95, Individual #160, Individual # 278, Individual #356, and Individual #124. ▪ **Interviews with**: o Michael Robinson, MSN, RN-BC, Chief Nurse Executive (CNE); o Colleen M. Gonzales, BSHS, Nurse Operations Officer (NOO); o Angela Roberts, Au.D., Director of Habilitation Therapies (HT); and o Rachel Martinez, QIDP Coordinator. ▪ **Observations of**: o ISP Meeting for Individual #333, on 10/1/13; o ISP Meeting for Individual #92, on 10/3/13; and o ISP Meeting for Individual #70 on 10/3/13.
	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: ▪ At the time of the review, the Facility had just begun to use their revised monitoring/auditing tools for Section I, to include all the provisions of the Settlement Agreement for the different subsections of Section I. Based on a review of the Facility's Self-Assessment: o Many of the metrics/indicators the Facility used for this section, as well as some of the data presented were in alignment with the Monitoring Team's metrics/indicators and some of the findings. As the Facility continues to revise and refine 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. In addition, in assessing quality of the documentation, the Facility should incorporate the use of nursing protocols and clinical pathways into the instructions to ensure that discipline-specific documentation is in alignment with the standards of practice for the particular discipline. On a positive note, at the time of the review, the Facility had begun having the specific disciplines review the documentation in their perspective areas. 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, the Facility did not yet have a consistent system for presenting data in a consistent and meaningful/useful way. Specifically, the Facility's Self-Assessment:

	o Did not present many 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 yet measure the quality of the documentation based on practice standards such as nursing protocols 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: At the time of the review, the Facility was in the process of identifying key compliance indicators for Section I in alignment with the Settlement Agreement and based on the elements the Monitoring Team reviewed. A review of the identified indicators contained in the Facility's Presentation Book for Section I found them to be very promising in reviewing a number of aspects regarding the At Risk system. In addition, the Facility appropriately revised its monthly monitoring tool for Section I in alignment with the elements of the Settlement Agreement and Monitoring Team's indicators and to accurately identify the Interdisciplinary Teams' areas of strengths and weaknesses regarding the ISP process. From the Facility's monitoring activities and deconstruction of a number of elements of the At-Risk system, the Facility developed an exceptional Facility training curriculum course that clarified a number of questions and areas of confusion that the teams were found to have regarding the At-Risk process. At the time of the review, the Facility's Self-Assessment indicated that in August 2013, 89% (107 of 120) of the staff required to attend had attended the training. It was positive that the Facility indicated that the specific disciplines would be participating in auditing the quality of the discipline-specific documentation and assessments required by the system. However, there was much work yet to be done to ensure that criteria such as nursing protocols and clinical guidelines/pathways are included in the instructions of any auditing tools developed and implemented. This is necessary to accurately assess compliance for any items addressing the quality of the documentation. Although the Facility clearly had invested a great deal of effort in clarifying and training staff regarding the At-Risk system at CCSSLC, the overall lack of clear documentation included in the ISPs, the Integrated Risk Rating Forms (IRRFs), the Integrated Health Care Plans (IHCPs), 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 addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes. 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 review, the Facility was in the process of identifying key compliance indicators for Section I in alignment with the Settlement Agreement and based on the elements the Monitoring Team reviewed. A review of the identified indicators contained in the Facility's Presentation Book for Section I found them to be very promising in reviewing a number of aspects regarding the At-Risk system. It was positive the Facility indicated that the specific disciplines would be participating in auditing the quality of the discipline-specific documentation and assessments required by the system. However, there was much work yet to be done to ensure that criteria such as nursing protocols and clinical guidelines/pathways are included in the instructions of any auditing tools developed and implemented to accurately assess the compliance for any items addressing the quality of the documentation. At the time of the review, this important step had not occurred. Thus, although the data presented in the Facility's Self-Assessment demonstrated that the Facility was beginning to move in the right direction in reviewing a number of areas related to risk, the data presented regarding the quality of the documentation regarding nursing and medical assessments did not consistently reflect the findings of the Monitoring Team as noted in the sections below. However, once this step is implemented at the discipline level and across all disciplines, it is the hope of the Monitoring Team that the overall quality of all the documentation for the At-Risk system will improve. ▪ In addition, since the last review, the Facility appropriately revised its monthly monitoring tool for Section I in alignment with the elements of the Settlement Agreement and the Monitoring Team's indicators. This should assist the Facility in accurately identifying the Interdisciplinary Teams' areas of strengths and weaknesses regarding the ISP process. ▪ As a result of the Facility's monitoring activities and deconstruction of a number	Noncompliance

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		of elements of the At-Risk system, the Facility developed an exceptional Facility training curriculum course that clarified a number of questions and areas of confusion that the teams were found to have regarding the At-Risk process. At the time of the review, the Facility's Self-Assessment indicated in August 2013, 89% (107 of 120) of the staff required to attend had attended the training. This included the following disciplines: 100% of QIDPs, 100% of Nursing, 88% of Habilitation Therapies and PNMT, 92% of Psychology, 100% of Psychiatry, 100% of Physicians, 90% of Program Coordinators (Active Treatment), 60% of Residential Coordinators, 100% of Dental, and 100% of Unit Directors. Also, the Facility indicated that 10 additional staff that were not required to attend did receive the training including three Program Compliance Monitors from the Quality Assurance Department, one Unified Records Coordinator, the PNMT Facilitator and PNMP Supervisor, and four Nurse Educators. ▪ The Facility also had the CNE, the Medical Director, the Pharmacist, and all contract physicians attend an ISP meeting to better understand the role of their and other disciplines regarding the ISP process as well as the specific documents required for each. Interviews with the Section Lead for this area indicated that this action significantly helped regarding the understanding of the overall At-Risk system and identified areas that needed further clarification. ▪ As a result of some of the actions noted above, the Facility indicated that it was in the process of developing a "Roles and Responsibilities" protocol for each discipline regarding the At-Risk process. From discussions with the Facility staff, this was a very thoughtful and positive step forward regarding outlining each disciplines' responsibilities addressing the risk process. ▪ The Facility's initial data regarding the Risk Screening Process generated from the observations of three ISPs conducted in June 2013 and the associated documentation was very promising. The Facility had incorporated many of the same indicators the Monitoring Team used for Section I, as well as adding a number of additional items such as the discussion of triggers for risk categories, whether or not appropriate referrals were made to the PNMT, whether or not the Active Problems list was up-to-date, and whether or not nursing protocols were used when discussing interventions and assessments for high and medium health risks. However, there were some indicators that included more than one element that should be separated so only one element is being scored at a time. For example, one of the indicators included the elements regarding "if the physician attended the ISP and was sufficiently prepared to discuss work-ups that have been completed in the past year, interpreted lab and test results for the IDT, provided details regarding the history as well as current health status of the individual, and recommended next steps." Although the information included in this indicator was important, it included several elements, and with only one compliance score, it would be impossible to interpret exactly what the	

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		score represented. ▪ In addition, another positive step was that since the last review, the Facility had put specific focus on the use of the Trigger Sheets and the direct support professional (DSP) Instruction Sheets. This was an effort to ensure that the DSPs were familiar with the steps and interventions contained in the plans they were responsible to implement, and that they document any triggers individuals demonstrate in order to continually monitor the status of the individuals. The Facility's Self-Assessment indicated that based on the findings of the self-assessment, the provisions for Section I were not in substantial compliance. The Facility clearly had invested a great deal of effort in clarifying and training staff regarding the At-Risk system at CCSSLC. However, the overall lack of clear documentation included in the ISPs, IRRFs, IHCPs, 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 addressing actions and completion of action plans made it difficult to sequentially follow the assessment and action plan processes for the sample of 22 individuals discussed with regard to Sections I.2, and I.3. Consequently at the time of the review, the Facility's efforts had not yet translated into any consistent measurable progress. To assess the Facility's revised risk screening process, members of the Monitoring Team observed three individuals' ISPs meetings (i.e., Individual #333, Individual #92, and Individual #70) while on site. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at none (0%) of the observed ISPs. o The Physician and Dietician were not present at the ISP for Individual #333 in spite of the fact that he had weight issues and had previously had a G-Tube placed related to not wanting to eat the Facility's food. o Individual #92's Pharmacist and Registered Dietician were not present. IDT Members Required for the Annual ISP Meeting, dated 7/5/13, did not require the attendance of the Registered Dietician and/or Pharmacist. However, the rationale provided in this document was not adequate to justify non-attendance by these members (i.e., Dietician/Nutritional Services-annual report will be presented by Habilitation Therapies and Pharmacy Services-annual assessment will be reviewed). Individual #92's Body Mass Index (BMI) was 39.2, which was 114 pounds above his ideal body weight range and he had lost 16 pounds over the previous year. The proposed recommendations in the	

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		draft IRRF stated: "continue with current diet and exercise plan." The expertise of the registered dietician would have been helpful to further explore ways to improve his weight status. Individual #92 was prescribed medication that would have benefitted from input from the Pharmacy Department. The Pharmacy section of the draft IRRF was blank and consequently the team did not have the expertise of the pharmacist during the meeting and/or any information provided in the IRRF. o For Individual #70, the PCP and Dietician were not present for the ISP, and the direct support professional was only present for part of the meeting due to having to tend to responsibilities in assisting Individual #70. ▪ 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 #333 and Individual #70 left the meeting as needed. ▪ The IDT consistently used the Risk Level Guidelines when determining risk levels at three (100%) of the ISP meetings. ▪ The IDT consistently used supporting clinical data when determining risks levels for one of the ISPs observed (33%). The IDTs for Individual #333, and Individual #92 did not consistently use supporting clinical data when determining risk levels. ▪ Overall, the risk levels the IDT designated were appropriate for each category for none of the ISPs observed (0%) 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 #333, Individual #92, and Individual #70. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in one (33%) of the ISPs meetings observed. The individuals' IDTs that did not have adequate and appropriate clinical discussion among team members included Individual #333 and Individual #92. ▪ Team disagreements regarding risk levels were noted in none of the ISP meetings. ▪ Based on all ISPs observed by the Monitoring Team, the ISP facilitators kept the team focused in two (67%) of the ISPs meetings observed. The Facilitator for Individual #333 had only recently been assigned to the ISP meeting due to the original Facilitator being ill, but did not consistently keep the team focused. In addition, other positive observations from the Monitoring Team included:	

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		▪ For Individual #70, the team discussed changes that needed to be made to his PNMP. ▪ At the beginning of the meeting, the QIDP for Individual #70 provided a good description of how the team should make use of his strengths and preferences. The team made some good use of this information. For example, the team used his strength of eye gazing in a community exposure goal and incorporated some of his preferences into the activities for this same goal, such as going to the bookstore or an Asian culture museum. Similarly, the team used his strength of imitating other's actions in developing a SAP related to turning the pages of a book and counting. ▪ Although not consistently documented in the preferences section of the ISP, many of the team members for Individual #333 were aware of his likes and preferences, especially regarding the food he liked at a particular restaurant in the community. ▪ The team members for Individual #92 consistently including him in conversations and decisions regarding his plan. Problematic areas needing focus or improvement included: ▪ The team for Individual #70 did not review the Integrated Health Care Plans and/or make revisions based on the team's discussion. Despite the QIDP Coordinator, who was observing, prompting the team to review the IHCPs, they did not. The team did not discuss measurable objectives or clinical indicators to assist them in determining whether Individual #70 was remaining stable, doing better, or doing worse. ▪ Although Individual #70 was doing well going to a day program for two hours two days each week, the team did not discuss expanding these hours. No medical or other reason was given for Individual #70 not participating in full day programming. ▪ Information provided in the IRRF for Individual #92 was not consistently adequate. For example, the IRRF data addressing choking stated: "he has a good oral health rating and only has a few missing teeth." Additional information should have been provided such as his oral health rating from last year in order to gage if progress had been made in this areas, as well as how many and specifically which teeth were missing. ▪ The current supports related to the choking risk factor for Individual #92 included quarterly meal monitoring checks that nursing had completed; meal monitors present at meal times to complete dining room observations; and compliance monitoring completed monthly by HT to address DSP compliance with following the dining plans/PNMP instructions during oral intake. However, none of the monitoring results were presented during the ISP. ▪ For Individual #92, the team did not discuss the inclusion of individual-specific	

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		triggers in the appropriate risk categories to alert staff to a change in status (e.g., respiratory compromise, cardiac disease, or weight). ▪ The teams for Individual #333 and Individual #92 did not consistently present sufficient clinical data from the current year as well as data from the past year to support the rationale for a risk rating. ▪ A draft copy of the IHCP was not available to IDT members for Individual #92 during the ISP meeting. In addition, the team did not stop at the conclusion of Risk Group I and refer to the draft IHCP for discussion of action steps. ▪ The proposed recommendations for Individual #92 should have been more aggressive for the risk factors that were rated high. For example, Individual #92's weight recommendations stated: "continue with current diet and exercise plan. Add formal exercise program when available." However, Individual #92's BMI of 39.2 placed him at high risk for multiple health concerns. The team, in collaboration with Individual #92, should have been more aggressive in discussing strategies for weight loss. ▪ Many of the likes and preferences for Individual #333 that the team were aware of, such as his ability to bounce balls, were not included in the ISP. ▪ The Team for Individual #333 did not review or address his previous placement of a G-tube related to not liking and thus, not eating the food at the Facility, which had resulted in weight loss in the past few years. However, the team indicated that the individual did regularly eat at a restaurant and his favorite food was "a loaded baked potato." There was no discussion regarding how his food preferences were to be addressed in conjunction with his weight issues in order to ultimately cease the need for the G-tube. In addition, there was no dietician present at the ISP meeting to provide information and direction to the team regarding this issue. When a member of the Monitoring Team asked a question about this issue at the meeting, rather than indicating the need to further assess the issue related to Individual #333's refusal to eat anything except a few specific foods from a behavioral aspect, the Behavioral Health Services Specialist asked if a referral to Psychiatry should be made to assess the need for psychotropic medications. Consequently, there was no plan in place to address the ongoing problem regarding his food preferences or his continuing to have an invasive G-Tube due to his refusals to eat food he does not like to eat. The team also indicated he sometimes refused medications, but this also was no addressed in an integrated fashion, taking into consideration various methodologies to assist him in improving medication compliance. ▪ In addition, in spite of behavioral issues reported regarding tooth brushing and SIB that Individual #333 clearly demonstrated during the meeting, the Behavioral Health Services Specialist indicated that Behavioral Health Services did not need to be involved. ▪ Although the Facilitator read the assessment conducted by the Dietician as	

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		requested by the Monitoring Team, the information regarding caloric intake did not accurately reflect all the calories that Individual #333 was taking in from his community trips to his favorite restaurant. ▪ Nursing was not using the nursing protocols when discussing needed interventions and assessments for the high and medium health issues for Individual #333. From the Monitoring Team's observations and record reviews, some positive steps were 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 the needed clinical intensity in alignment with the appropriate designated risk levels and include nursing assessments in alignment with nursing protocols, 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.	Based on a review of records for 22 individuals determined to be at risk (i.e., Individual #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections), 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: ▪ 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, 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	Noncompliance

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		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, one (5%) included 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 (i.e., Individual #86). As noted in previous reports, nursing had no specific procedure in place addressing the process regarding the nursing assessments and the 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 or merely including the care plan in the assessment without addressing the individuals' actual health status. More specific details are provided with regard to Section M.2. 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> Ten records were reviewed to determine adequacy of risk assessment and completeness of risk reduction plans. These included the records for: Individual #333, Individual #311, Individual #127, Individual #369, Individual #113, Individual #95, Individual #160, Individual # 278, Individual #356, and Individual #124.	

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		The following provides more detailed information about the findings of the reviews: ▪ The IRRF for Individual #95 indicated that this individual had 12 teeth pulled during the year. The individual had poor oral hygiene practices. There was noted anxiety with dental care, and assistance was needed in completing tooth brushing. The individual required TIVA during the year, had moderate periodontitis, and the oral hygiene rating was considered good. Despite the loss of teeth, moderate periodontitis, and lack of oral hygiene practices, the conclusion was that "current supports appear to be effective." This would need further explanation, as loss of multiple teeth was an undesired outcome and suggested the need to review supports provided to maintain oral hygiene, and an increased focus on dental hygiene for the IDT. There was no additional step such as increased monitoring of dental care to determine whether the needed assistance was provided, whether the direct support professionals needed additional training or support from the Dental Department, whether the assistance was resisted or accepted by the individual, a determination of steps including oral sedation to reduce the anxiety in visits to the dental office, etc. Twelve extractions and poor oral hygiene practices suggested the need for urgent, aggressive review of needed supports to reduce further tooth loss. The IRRF did not provide rationale for indicating "current supports appear to be effective." ▪ Individual #369 most recently had a poor oral hygiene rating. Examination under TIVA indicated severe periodontitis. This individual required annual TIVA exam and treatments. The individual had lost six teeth. A desensitization plan was in place, but there was little progress. It was known the individual did not like others brushing the teeth. The individual was to be prompted daily to brush teeth with an electric toothbrush. Despite the poor oral hygiene rating, severe periodontitis, lack of progress with desensitization, and resistance to assistance with tooth brushing, the IRRF indicated that the "dental current supports appear to be effective." The rationale for this conclusion was not clear. Conversely, the supports in place, of which there were several, (i.e., TIVA, etc.) had not improved the individual's oral hygiene rating or severe periodontitis. For instance, with lack of progress with the desensitization plan, a review of this plan was indicated. There was no discussion whether further teaching and monitoring of direct support professionals had been done or was considered. There was no mention of preference for toothpaste flavor choice, or other behavioral steps to motivate the individual to brush one's teeth. ▪ Individual #333 had two teeth extracted in 2/2013. The oral hygiene rating was considered good at that time and had declined to fair on 7/23/13. The individual had a total of 11 missing teeth. Despite the undesirable outcomes of further loss of teeth and worsening oral hygiene rating, the IRRF indicated	

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		"current supports appear to be effective" without further explanation. From the information provided, it appeared the dental status had declined, which would indicate need for further review. It was not clear how the current supports were considered effective, and further justification was needed for that statement. A comprehensive nursing review of 9/13/13 documented that "supports in place have proven partially effective." This may have been a more accurate statement. The IDT is encouraged to consider options to improve effectiveness of supports to minimize tooth loss and maintain and/or improve oral hygiene. ▪ Individual #160 had a gastrostomy tube (G-tube) placed several years prior. There was a diagnosis of reactive airway disease treated with nebulizer treatments. The most recent quarterly nursing assessment documented 117 episodes of dysphagia/ aspiration triggers including cough with struggle and formula coming from mouth and nose. Twice the individual required Infirmary admission for reactive airway disease and required prednisone on the last admission of 5/25/13. Reactive airway disease can be a result of severe GERD with aspiration of stomach content into the lungs, setting off bronchospasm, and causing chemical pneumonitis. There was a history of delayed gastric emptying, which appeared to be intermittent. An EGD ruled out pyloric obstruction. At that time, the gastrointestinal (GI) consultant indicated that: "…appears the patient is regurgitating tube feedings possibly resulting in cough. We can try changing the G-tube into a GJ [gastrostomy/jejunostomy] tube." Many additional IPNs documented spitting up formula and finding milky phlegm. A pulmonology consult of 7/16/13 recommended starting Reglan and reducing the feeding rate. The office note indicated: "tube feeding found in oral cavity and hypopharynx." The pulmonologist saw the individual on a follow-up visit of 8/13/13 and indicated the individual was doing well after additional medication and physical management recommendations. There was no follow-up to the GI consultation for the consideration of a GJ or J-tube in the documents reviewed. There did not appear to be any documented follow-up discussion by the PCP with the pulmonologist or the GI consultant, or a consideration of a surgical consult for other aggressive options, in order to optimize health care collaboration and offer all appropriate options to the individual. Ruling out severe GERD was important to ensure this was not contributing to the intermittent reactive airway disease. If severe GERD were present, then the individual would continue to be at risk for a recurrence unless GERD was aggressively treated, and quality of life would be compromised by recurrent respiratory illness. The Facility's clinical guideline provided guidance and expectations in this area, but the active record did not appear to reflect adherence to the clinical guideline. The pulmonologist appeared to maximize medical options and physical management, but there was no information in the IPNs or IDT discussions concerning consideration of additional or next steps such as surgical options (i.e., fundoplication, J-tube	

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		placement, etc.) according to the clinical guideline, which might be applicable in treating this individual. It was not clear if there was family or guardian involvement in learning of options or making choices. Additionally, there was no mention in the IRRF of this individual receiving suction tooth brushing. It would appear the individual was a candidate for suction tooth brushing to ensure there was no aspiration during oral care. The oral hygiene rating was fair, and there might be additional benefit from attempting to improve the oral hygiene rating. There was no discussion of how the individual's oral health could be further improved. The IRRF also did not mention how the individual would be monitored to ensure the head of bed elevation occurred even during bathing or changing. The pulmonologist recommended the head of bed elevation at greater than 45 degrees at all times. Continual refresher training of direct support professionals caring for the individual was indicated, because even one incidence in which the individual was allowed to lie flat while feeding was occurring or had occurred recently could result in significant reflux and aspiration. This ongoing challenge in physical management needed to be carefully monitored around the clock. Given the diagnosis of reactive airway disease, there was no discussion in the IRRF concerning monitoring of the home and day program environment to ensure an optimal environment (i.e., minimize dust, pollens, fumes, etc.) along with reduction of potential chemical cleansers, which might be respiratory irritants to the individual. ▪ Individual #127 was hospitalized three times in the past year for respiratory distress, two of which were due to aspiration pneumonia. This individual had a history of reactive airway disease. One of these hospitalizations was preceded by an IPN describing the respiratory distress: "rapid labored breathing first noted earlier this afternoon at about 515PM after bathing." Despite three hospitalizations for respiratory distress, of which two were aspiration pneumonia, there was no information to indicate that the severity of GERD had been evaluated and treated with additional medical and/or surgical options. There was a difference in the steps to be considered in the clinical guideline and the steps taken. Other than ordering a proton pump inhibitor, there did not appear to be any additional evaluation or treatment of GERD. The IPN description of the event was consistent with the individual having refluxed when bathing occurred (i.e., placed in flat position without head elevated). Additionally, there was consideration of a determination of allergens (recorded in an PNMT note of 2/5/13) by consulting an allergist, but the active record did not appear to provide closure to this concern. 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.	

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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 #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections), 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%). Although all 22 individuals were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 22 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, 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 and exercise, 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 IHCP/Risk Action Plans into the ISPs in 22 of the 22 cases (100%). ▪ None (0%) of the plans reviewed 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 Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it	Noncompliance

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		was not addressed. 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.	

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 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 10 examples of recently completed CPEs; o Spreadsheet listing the individuals who are followed in the Neurology Clinic with notation 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 individuals jointly followed by Neurology and Psychiatry who were reviewed in the August 2013 Neurology Clinic; 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 records 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 and Addendums, Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section, for the following individuals the Facility selected: Individual #67, Individual #304, Individual #183, Individual #90, Individual #13, Individual #118, Individual #371, Individual #376, Individual #202, and Individual #72; o The same documents from the active record as listed above for following individuals who were selected based on the acuity of their psychiatric presentation: Individual #177, Individual #325, Individual #20, Individual #119, Individual #300, Individual #40, and Individual #348; 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 10/1/13, and who were not prescribed psychotropic medication; o Curriculum Vitae (CV) and Contracts for the following: Dr. Gollavelli Krishna, Chief of Psychiatry, and Dr. Michael Hernandez, Consulting Psychiatrist; o MOSES and DISCUS side effect rating scores for the last year for the following four individuals receiving Reglan who were not also receiving a psychotropic medication: Individual #43, Individual #270, Individual #266, and Individual #189; 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 one through three and Recommendations seven through 10; o Restraint documentation related to the administration of the following six incidents of chemical restraint and the (date): Individual #7 (7/1/13), Individual #169 (4/29/13), Individual #144 (3/15/13), Individual #275 (3/13/13), and Individual #348 (2/11/13); o Clinical documentation related to the 10/1/13 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 six months, 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 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 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 nursing staff received with regard to completing the DISCUS evaluations; o Consent packets for psychotropic medications for the individuals reviewed during the Human Rights Committee (HRC) Meeting on 10/2/13; o Consent Tracking database/spreadsheet maintained by the Psychiatry Department; o Individuals discharged to the community who were prescribed psychotropic medications in the last six months; o A blank copy of the policy/shells revised on Psychiatric Symptom Tracking; o Most recent standardized CPE template; o The Psychoactive Medication Treatment Plan (PMTP) and the Integrated Risk Rating Form (IRRF) for the following individuals: Individual #72, Individual #118, Individual #371, Individual #61, Individual #13, Individual #183, Individual #376, Individual #119, Individual #300, Individual #304, Individual #202, and Individual #20; and o Ten recently completed CPEs that did not overlap with the 17 individuals in the sample. ▪ **Interviews with:** o Gollavelli Krishna, M.D., Chief of Psychiatry, on 9/30/13; o Glynn Bogard, Psychiatric Assistant; Michelle P. Lora-Arteaga, R.N., and Lindsay Hertz, R.N., Psychiatric Nurses; and Joseph Ward, Psychiatric Assistant, on 9/30/13 and 10/1/13; o Michael Hernandez, M.D., Consulting Psychiatrist, on 10/1/13; o Judy Sutton, MS, BCBA, Director of Behavioral Services, on 10/2/13; o Gary French, R.PH and Dennis Palmer, R.PH on 10/1/13; o Enrique Venegas, D.D.S.; and Kathy Roach, Dental Hygienist, on 10/1/13; o Brief discussion with Karen Forrester, Human Rights Officer, and Glynn Bogard, Psychiatric Assistant, after the HRC Meeting, on 10/2/13; o Glynn Bogard, Psychiatric Assistant, Araceli Matehuala, Program Compliance Monitor for Psychiatry, and Gollavelli Krishna, M.D., Chief of Psychiatry, to review Facility Self-Assessment, on 10/3/13; and o Glynn Bogard, Psychiatric Assistant; Michelle P. Lora-Arteaga, R.N., Psychiatric Nurses; Joseph Ward, Psychiatric Assistant; and Gollavelli Krishna, M.D., to review the Psychiatry Department's status of the 15 provisions of Section J, on 10/3/13. ▪ **Observations of**: o Psychiatric Clinic, on 10/1/13; o Polypharmacy Committee Meeting, on 10/1/13; o HRC Meeting, on 10/2/13; o Pre-Treatment Sedation Desensitization Meeting, on 10/2/13; o The following individuals were observed during the onsite review of the residences and program sites: Individual #298, Individual #367, Individual #12, Individual #297,

	Individual #263, Individual #316, Individual #96, Individual #267, Individual #95, Individual #172, Individual #169, Individual #254, Individual #151, Individual #90, Individual #7, Individual #97, Individual #323, Individual #295, Individual #318, Individual #238, Individual #92, Individual #191, Individual #158, Individual #218, Individual #13, Individual #348, Individual #37, Individual #118, Individual #275, Individual #312, Individual #296, Individual #144, Individual #115, Individual #268, Individual #308, Individual #332, and Individual #42.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section J, which was dated 9/13/13. 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. 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 the interviews with the PCM for Psychiatry, and the lead Psychiatric Assistant, a member of the Monitoring Team made the following observations: ▪ The audit tool for Section J was developed within the Facility, but was derived from the audit tool DADS State Office developed. An additional methodology the Facility utilized was review of longitudinal spreadsheets/databases that were continuously updated. The specific application of these methods is described below. ▪ 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. ▪ The monitoring tools consisted of methodologies that included an analysis of item-specific, cross-sectional data, which utilized a large number of records, as described below. Another corollary methodology utilized databases to monitor the Psychiatry Department's progress toward completing specific evaluations for all individuals prescribed psychotropic medication. ▪ 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. ▪ During the 10/3/13 meeting related to this subject, the PCM, the Psychiatric Assistants, and the Chief of Psychiatry reviewed the current progress for the monthly Quality Assurance Reviews of individual records. Every month, four individual records were selected and distributed for review: one each to the two Psychiatric Nurses, and one each to the two Psychiatric Assistants. The PCM reviewed two of these while blind to the other 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 to 100 percent. The lead Psychiatric Assistant also performed sample-based, cross-sectional analyses for specific provisions. Only this individual completed those reviews. ▪ The monitoring tools had some guidelines to ensure consistency in monitoring 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 review of specific

	documents, standards of quality, required sample size and the necessary degree of inter-rater reliability. ▪ The following staff members were responsible for completing the audit tools: the PCM assigned to the Psychiatry Department, the two Psychiatric Assistants, and the two Psychiatric Nurses. The item-specific, cross-sectional analyses referred to above were performed only by the lead Psychiatric Assistant. The review of longitudinal databases, used for many sections, were a joint effort between the Psychiatric Nurses and the Psychiatric Assistants. ▪ The Psychiatric Department staff members responsible for conducting the audits appeared to be clinically competent 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 and valid manner. The PCM attended Polypharmacy Meetings and attended Psychiatric Clinics to the extent possible in order to become more knowledgeable about the clinical issues and processes. This staff member did not score items that would require clinical expertise to make an initial assessment of quality, but did score for the presence or absence of items. For example, the PCM would score for consistency of the psychiatric diagnosis between different sections of the record, but would not comment on the validity of that diagnosis. However, with the progression of time and continued refinement of the audit tool, these reviews had become more sophisticated, as the Facility's inclusion of psychiatric diagnostic checklists increased the validity of the review process. The PCM also checked to make sure the DADS policy related to specific provisions was followed. For example, with regard to documentation from a Neurology Consultation, she would check to see if it occurred in a timely manner and if the referral question was addressed in the Consultation. 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 documents reviewed. o 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. o In addition to the audits of 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 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); the specifics of Neurology Consultations (i.e., name, date, date of Consultation, date of Psychiatry Review) (J.15); the attendance of Psychiatric team members at ISPs and the Behavioral Support Committee Meetings (Section J.8, Section J.9, and Section J.10); and the changes in psychiatric diagnosis and the coordination of the multidisciplinary team input into the record for pre-treatment sedation when needed. They were able to utilize this information to document completion rates for the entire population of individuals receiving psychotropic medication. o 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 and 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 cross-sectional studies was not clearly stated. o The Facility organized its self-assessment around specific indicators derived from the Settlement Agreement and the Monitoring Team's prior reports. o The Facility rated itself as being in substantial compliance with the following eight sub-sections of Section J: Section J.1, Section J.2, Section J.6, Section J.7, Section J.11, Section J.12, Section J.13, and Section J.15. o The comparison of the Facility's ratings and those of the Monitoring Team for those provisions where there was a difference between the two ratings differed only for Section J.14. The discrepancy between the findings of the two ratings for Section J.14 appears to derive from the observation that the Facility found that 100 percent of the records they reviewed contained documentation of the necessary signed Informed Consent Forms for psychotropic medication, with the only deficit being in the description in the individual records of alternate strategies which had, or could be, considered. This information was contained in the PMTP, the systemic completion of which was also part of the post-April 2013 initiative. The language of this section of the Settlement Agreement does not mention the need for a reference to less restrictive alternative strategies and concerns itself only with the identification of "associated risks." The primary emphasis of this section is "shall obtain informed consent or proper legal authorization (except in the case of emergency) prior to administering psychotropic medication or other restrictive procedures" Thus, both the Facility's internal review and this external monitoring review found that this had been accomplished as based on these samples. o The Facility data identified areas in need of improvement. The Facility Self-Assessment provided some limited analysis of the information. This identified potential causes for the issues, but did not perform a detailed, root-cause analysis.
	Summary of Monitor's Assessment: At the time of the Monitoring Team's previous review, the Facility recently had employed a full-time locum tenens Psychiatrist, as well as a full-time Board Certified Psychiatrist who assumed the position of Chief Psychiatrist. The Consulting Psychiatrist also continued for eight hours per week. Since the Monitoring Team's previous review, the locum tenens Psychiatrist had left the Facility. At the time of the current review, the Consulting Psychiatrist continued to supply the direct psychiatric services to the individuals residing at CCSSLC through the Psychiatric Clinics, while the Chief Psychiatrist assumed the responsibility for completing and updating the CPE, performed Psychiatric Consultations as needed, and also attended to the numerous administrative responsibilities. The Psychiatrists continued to be supported by two full-time Psychiatric Nurses and two Psychiatric Assistants, who provided the infrastructure necessary for the Department to continue to make progress. During the Monitoring Team's previous review, one of the challenges that confronted the Psychiatry Department at CCSSLC was the integration of the clinical material, described in Section J.8, Section J.9, and Section J.10 into the ISP documentation. The Facility's plan at that time was to include information from the newly developed PMTP with the IRRF documentation that would be sent to the IDT for discussion at the pre-ISP meeting, as well as the annual ISP meeting. In addition, at the time of the previous review, the Department was beginning an initiative that would enable a member of the Psychiatry Team to participate

	in the discussion of this material at the individuals' annual ISP meetings. These initiatives were designed to address the requirements to integrate relevant aspects of the individuals' Psychiatric Treatment Plan into the ISPs. The Facility's internal data indicated that after April 2013, a member of the Psychiatry Department attended 95 percent of the ISPs for individuals prescribed psychotropic medication. This was a positive development, but more work was needed to ensure that teams had discussions and documented the necessary deliberations related to the use of psychotropic medications and alternatives. Another major challenge was the continued high rates of polypharmacy. At the time of the last review, the Psychiatry Department had begun to organize this data on a categorical basis to enable the Psychiatric Team to both assemble and then effectively present the necessary historical information to justify the continued use of medication. Since then, this initiative had been completed and provided the necessary information for a significant number of these individuals. CCSSLC had maintained thorough documentation of the symptoms needed to establish the individual's psychiatric diagnosis, as well as the differentiation of those behaviors derived from the psychiatric diagnosis, as opposed to those present on a behavioral basis. The Chief Psychiatrist had assumed the responsibility for completing and updating the CPEs, and had brought the completion rate for updated CPEs back to a 100 percent completion rate.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	At the time of the review, Dr. Michael Hernandez, who was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, was CCSSLC's Consulting Psychiatrist. During the interviews, which took place during the Monitoring Team's current and previous 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 community mental health clinic. At the time of the 10/1/13 Psychiatric Clinic, Dr. Hernandez stated that he continued to treat a significant number of individuals with ID/DD in his private practice. He estimated that he had engaged in providing psychiatric services to individuals with ID/DD for over six years, and had been a Consulting Psychiatrist 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. Prior to the Monitoring Team's last review, the Facility hired Gollavelli Krishna, M.D., who began in mid-March 2013 on a full-time basis, as the Chief of Psychiatry. 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,	Substantial Compliance

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		after passing the Educational Commission for Foreign Medical Graduates (ECFMG) and Federation of State Medical Boards Licensing Examination (FLEX). 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, she did have extensive experience with both the clinical and administrative responsibilities related to public sector psychiatry. The Facility was found to be in substantial compliance with this provision, based on the fact that the American Board of Psychiatry and Neurology certified Drs. Hernandez and Krishna in Adult Psychiatry. In addition, Dr. Hernandez 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 she had a solid grasp of the clinical issues presented by individuals who have both mental illness and ID/DD. Her direct knowledge of the special psychiatric needs of individuals with ID/DD continued to expand during the six months she has worked at CCSSLC.	
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.	During the 9/30/13 interview with the members of the Psychiatry Department, the Chief Psychiatrist indicated that the Consulting Psychiatrist had continued to follow the individuals prescribed psychotropic medication through the format of the Monthly and Quarterly Psychiatric Reviews. The Chief Psychiatrist had assumed responsibility for updating the CPEs and other documentation related to the Annual ISP meeting, such as the PMTP. In addition, she also performed any psychiatric consultations required in between the routine Psychiatric Clinics. 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, the Quarterly Psychiatric Reviews, and the DSM-IV-TR [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision] Diagnostic Checklist, which was a separate document. 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 Monitoring Team's previous reports, 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 prescribed psychotropic medication. The Facility's status with regard to the CPEs is discussed in detail with regard to Section J.6. The discussion here primarily relates to the results obtained by the comprehensive review of records of 15 percent (N=17) of the 112 individuals prescribed psychotropic medication at the time of the Monitoring Team's	Substantial Compliance

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		onsite review. The review of the clinical record of these 17 individuals indicated that there was adequate clinical justification for the diagnosis of record for all of the 17 individuals (100%) identified in the sample. 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 all 17 individuals (100%) had been updated within the prior 12 months. The material in the Quarterly Psychiatric Review documentation that specifically addressed this was the diagnostic section, which included a listing of the overt symptoms of the disorder with which the individual presented. The "DSM-IV-TR Diagnostic Checklist" was a separate document that reproduced the diagnostic criteria for an individual's diagnosis (as listed in the DSM-IV-TR), and then the specific symptoms manifested by the individual were checked off, so that it was easy to determine if the DSM-IV-TR criteria for that diagnosis had been met. In addition, CCSSLC previously had developed psychiatric symptom-tracking scales. These scales initially 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. This instrument subsequently had evolved into a more concise document that covered eight categorical domains derived from the symptoms related to the major Axis I psychiatric diagnosis. This revised form currently was awaiting approval by the QA/QI Committee. Accordingly, this instrument was not in use at the time of the Monitoring Team's current review. CCSSLC also maintained data on the number of psychiatric diagnoses modified or changed over the last six months. 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 in the sample of 17 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 receiving psychotropic medication also confirmed these observations. An issue the Monitoring Team identified in its previous reports with regard to psychiatric diagnoses was related to the observation that 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. Both the prior and current reviews found that this problem had been rectified and did not occur in	

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		any of the individual records reviewed. The Facility's improvement in this regard was primarily due to two systematic changes that the Psychiatry and Behavioral Health Services Departments had implemented in their respective documentation. These changes 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 was clarified in both the CPE and the Quarterly Review Psychiatric 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 commanding them to hurt someone. The Behavioral Health Services Department had added a section to their documentation entitled: "Psychiatric Information." This section included the psychiatric diagnosis, as well as the impact of that psychiatric disorder on the individual's challenging behaviors. However, references to the interaction between the individuals' psychiatric diagnoses and their maladaptive behaviors appeared throughout the Psychology section of the record, and were not confined to just this specific section. Thus, it was possible 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 was based on the consistency with which these 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 spreadsheet that tracked the completion dates of the CPEs indicated there had been a prior CPE completed within the last 12 months for all (100%) of the 112 individuals prescribed psychotropic medication.	
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,	The individual interviews with members of the Psychiatry Department, as well as the review of the records of 17 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 33 percent of the 112 individuals prescribed psychotropic medication.	Noncompliance

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	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 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 Section J.2, Section J.6, and Section J.13. In addition, the review of the spreadsheet listing all of the individuals prescribed psychotropic medications indicated each of these individuals had a psychiatric diagnosis of record. The 17 records reviewed indicated 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 were potentially being used in the absence of adequate behavioral treatments or interventions. At the time of the Monitoring Team's previous review, the Psychiatry Department, working in conjunction with the Behavioral Health Services Department, had effectively addressed this problem through the development of collaborative, systemic methods. The current review found that these collaborative methods had been effectively continued and maintained. These methods are described in detail in with regard to Section J.2, and summarized with regard to Section J.8, Section J.9, and Section 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 reviewed for five unique individuals who had	

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experienced an incident that involved the use of chemical restraint in the last six months. This information was included in the documents provided prior to the Monitoring Team's onsite review, and is summarized below:

INDIVIDUAL	DATE	TIME	MEDICATION
Individual #7	7/1/13	5:00 p.m.	Zyprexa (Zydis) 10 milligrams (mg) by mouth (PO)
Individual #169	4/29/13	5:55 p.m.	Zyprexa 10mg IM
Individual #144	3/15/13	12:40 p.m.	Ativan 1mg IM
Individual #275	3/13/13	2:04 p.m.	Zyprexa 10mg IM
Individual #348	2/11/13	4:15 p.m.	Zyprexa 10mg IM

The individual restraint data was reviewed for the presence and quality of the five components of 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, the documentation contained in all 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 7/1/13 (5:00 p.m.) chemical restraint for Individual #7 was as follows:

   "[Individual #7] was threatening to kill peers, refusing to sleep, very agitated and asking to be sent to SASH."

   The corresponding information for the 3/15/13 (12:40 p.m.) chemical restraint for Individual #144 stated:

   "Aggressive, agitated, pulling off helmet causing him to hurt himself by bumping his head."

   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 required to determine the

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		antecedent events to the incident. This information would be essential for determining if the circumstances that preceded the incident provoked the aggressive behavior and/or if the behavior could have been avoided. Thus, the record review indicated this section of the documentation was completed in an adequate manner for none of the five individuals (0%). This information also would be of use to the individual's Behavior Health Specialist 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 Behavioral Health Services Department should further investigate this observation to ascertain if changes in the format of the documentation and/or additional trainings 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 information that described the attempts to de-escalate the situation. 3. The physiological post-restraint monitoring portion of the documentation was completed for four of five individuals in this sample (80%). This section of the documentation for the 7/1/13 (5:00 p.m.) episode of chemical restraint for Individual #7 contained only information related to baseline monitoring, with no subsequent follow-up data. 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%) in a timely manner. The AVATAR computer-generated forms contained only the following three options for the Psychiatrist: <u>*Psychiatrist Review*</u>*:* *Documentation shows medication used in a clinically justified manner?* *If no, Explain:* *Potential medication-related risks?* *If yes, Explain:* *Actions/Recommendations:*	

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		The corresponding yes/no answers for the Pharmacist were: *Pharmacist Review:* *Documentation shows medication used in a clinically justified manner?* *If no, Explain:* *Potential medication-related risks?* *If yes, Explain:* *Actions/Recommendations:* However, there were spaces on the form for free-text comments, which generally contained brief comments concerning a few potential risks of the medication used. There was no specific discussion of the circumstances related to the incident being reviewed. Accordingly, it was not clear that the material had been reviewed with the degree of specificity that would be required to provide useful feedback to the IDT. 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 none (0%) of the five individuals in this sample. However, this finding was primarily due to the absence of the description of antecedent events that would provide a context for the incident. This information, which is provided by staff members present as the incident was evolving, would be useful for future planning to prevent a reoccurrence. As detailed above, CCSSLC had made progress with regard to the differentiation of psychiatric symptoms and behaviors 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 was 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. Although, no instances were found 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.	
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	At the time of the Monitoring Team's previous reviews, 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	Noncompliance

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	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.	Nurse, the Unit Nurse, the Primary Care Practitioner (PCP), the Behavioral Health Specialist, 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 who required these interventions (100%). In addition, the Quarterly Psychiatric Review documentation for each of the 17 individuals in the review sample (100%) contained a copy of the documentation from the Psychiatric Clinic, during which this subject was discussed for each individual. Specific concerns related to the quality of the current Desensitization Plans and other strategies to reduce the need for pre-treatment sedation are discussed with regard to Section C.4 of the Settlement Agreement. However, at the time of the Monitoring Team's 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 spreadsheet dated 9/4/13 entitled: "Psychology Master Desensitization Need List" contained four alphabetical listings of individuals. The spreadsheet included their residence and multiple columns that were specific to each of the four sub-groups of individuals. The first group listed 98 individuals and functioned as a working list to help track the progress of these individuals in meeting the goals of their active Desensitization Plans. The second group essentially represented a sub-group of the first group (N=16) that listed those individuals who required Desensitization Plans only for medical procedures, as they were edentulous or did not require pre-treatment sedation for dental procedures. The third group (N=127) was comprised of those individuals who had previously been determined to not be a candidate for a Desensitization Plan. As described above, the primary reasons for an individual being determined to not be a candidate were the presence of factors, such as physiological spasticity, or extreme baseline innate motor hyperactivity. This list also included those individuals who received general anesthesia for dental procedures and, thus, the Facility had determined did not require pre-treatment sedation for dental procedures. Given that general anesthesia is a form of sedation, and in fact, has significant risks involved, it was not at all	

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		clear how the Facility had determined that this group of individuals did not need to be included in efforts to reduce to the extent possible the use of pre-treatment sedation. The fourth group consisted of a brief listing of individuals (N=9) who needed to be removed from the database due to administrative reasons, such as a geographical move (or death). 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. Members of the Monitoring Team attended the 10/2/13 meeting of the Pre-treatment Sedation Desensitization Committee. The following professional disciplines attended this meeting: Medicine, Dental, Nursing, Psychiatry, Behavior Health Services, Unit Administrators, and the QIDPs. The focus of the meeting was on those individuals who were scheduled to have dental and/or medical procedures in the month of October, in order to proactively develop strategies that would minimize the need for pre-treatment sedation to the extent possible. Similar meetings had been held on 8/13/13, and 7/3/13. During the 10/2/13 interview with the Director of Behavioral Services, she indicated that a meeting was not held in September and, thus, those clinical planning discussions had not taken place for that month. The Dental Services Department maintained data on the frequency with which 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 those appointments from 2/1/13 through 8/31/13, for which no sedation was required.	

DATES	NUMBER OF APPOINTMENTS	NUMBER (%) PRE-TREATMENT ORAL SEDATION	NUMBER (%) IV SEDATION/ GENERAL ANESTHESIA	NUMBER (%) REQUIRING NO SEDATION
2/13	175	3 (1.7%)	7 (4.0%)	165 (94.2%)
3/13	107	1 (0.9%)	5 (4.7%)	101 (94.3%)
4/13	102	2 (1.9%)	7 (6.8%)	93 (91.2%)

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5/13	75	1 (1.3%)	6 (8.0%)	68 (90.7%)
6/13	122	3 (2.4%)	8 (6.5%)	111 (90.9%)
7/13	124	4 (3.2%)	7 (5.6%)	113 (91.1%)
8/13	121	1 (0.8%)	4 (3.3%)	116 (95.8%)

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 2/1/13 through 8/31/13 confirmed that during that time period the orders were primarily for the following medications: Ativan (a benzodiazepine), in a range from one mg to three mg; Atarax (an antihistamine with sedative properties), in a range from 25 mg to 50 mg; or Halcion (Triazolam), in a range from 0.5 mg to .75 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 procedure for the multidisciplinary review of the individuals' pre-treatment sedation in the context of the Quarterly Psychiatric Reviews.

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 the residence. The IV anesthesia monitoring was very detailed. The Consultant who administered the anesthesia also performed the monitoring. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments, and for the use of IVs anesthesia, 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, which detailed the utilization of pre-treatment sedation from 2/1/13 through 7/31/13, revealed that during this timeframe, there were 55 unique instances of individuals receiving pre-treatment sedation for medical procedures, as compared to 14 for dental procedures. This finding is similar to that described in the Monitoring Team's prior report, which indicated that, although the precise ratio varied over time, the number of

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		administrations of medical pre-treatment sedation always greatly exceeded the corresponding frequency for dental procedures. The majority of the orders for medical procedures were for Ativan, in a range of 0.5 mg to four mg; and/or Atarax, in a range of 25 mg to 50 mg; Xanax, in a range of one mg to two mg; and Halcion 0.75 mg. Overall, the medications utilized appeared to be appropriate and were prescribed in moderate dosages. As indicated above, the Behavioral Health Services Department had begun to develop Desensitization Plans for medical procedures, but this process was not as advanced as the corresponding initiative for dental procedures. CCSSLC had an effective process in place for coordinating pre-treatment sedation for dental procedures with other professional disciplines, including Psychiatry, Pharmacy, Medicine, and Nursing. However, there did not appear to be a corresponding system to develop pre-treatment sedation for medical procedures. It would be useful to extend this process to include pre-treatment sedation for medical procedures. At the October meeting of the Pre-Treatment Sedation Committee, there was a multidisciplinary discussion of everyone who was known to have a medical appointment for which they might require such sedation in the coming weeks. These were very detailed discussions that included both interpersonal interventions as well as pharmacological considerations. However, this meeting had not been occurring every month and it was not clear with what regularity it would be maintained going forward. The finding of noncompliance for this provision was based on the observation that fully 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 plans for medical services. In addition, in their efforts to reduce the use of sedation to the extent possible, the Facility will need to include individuals that require general anesthesia for appointments that typically would not require such an intervention in the general population.	
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	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. At the time of the Monitoring Team's previous review, the professional support staff of the Psychiatry Department indicated the above determination was supported by an	Noncompliance

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	this section of the Agreement.	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, at the time of the last review, the Monitoring Team determined that these were opinions that 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, which 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 individuals prescribed psychotropic medication, attend the ISP meetings, and complete the CPEs on an annual basis. It concluded 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 assistance that was provided by the four members of the Psychiatry support team. During the Monitoring Team's previous review, the Facility relied on one part-time Consulting Psychiatrist to provide the day-to-day psychiatric care to individuals prescribed psychotropic medication. At that time, his weekly allotment of time 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 full-time equivalent (FTE) Psychiatrist. As noted above with regard to Section J.1, the Consulting Psychiatrist was Board Certified in Adult Psychiatry. At that time, an additional locum tenens Psychiatrist was working on site, on a full-time basis, and was expected to remain for at least the remainder of the calendar year. His time was devoted to completing the CPEs for individuals prescribed psychotropic medication. In addition, the Facility had been able to recruit a new full-time Psychiatrist, who would also assume the administrative responsibilities of the Chief of Psychiatry. Besides her administrative responsibilities, this Psychiatrist would become responsible for the direct clinical care of a portion of the residents. However, at the time of the previous review, the distribution of the clinical caseloads between the Consulting Psychiatrist and the new Chief of Psychiatry had not yet been determined. The Monitoring Team's previous review also noted that 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. The infrastructure created, and the ancillary services provided, made it possible to maximally utilize the amount of psychiatry time available to the Facility.	

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		At the time of the Monitoring Team's previous review, CCSSLC was found to be in substantial compliance with this provision of the Settlement Agreement, because the total number of FTE Psychiatrists was 2.2, and the Facility's analysis of the Psychiatrists' time allocation indicated that two FTEs should be sufficient. A member of the Monitoring Team reviewed this analysis and found it to be reasonable. The Monitoring Team's prior Report indicated that if the current locum tenens Psychiatrist were to leave and/or was not replaced with another full-time Psychiatrist, this could change the finding to noncompliance in future reviews. The locum tenens Psychiatrist working at CCSSLC at the time of the Monitoring Team's April 2013 review left the Facility in the months following that review. As noted with regard to Section J.1, the Consulting Psychiatrist had continued at eight hours per week, which was primarily allocated to providing direct services to the 112 individuals prescribed psychotropic medications through the Monthly and Quarterly Psychiatric Reviews. The full-time Chief Psychiatrist devoted her time to the development of the CPEs for newly admitted individuals, the updating of the CPEs for those individuals who already had an initial CPE, preparation of the PMTPs, Psychiatric Consultations on clinical issues that arose outside of the Psychiatric Clinic schedule, and numerous administrative responsibilities. During the course of the Monitoring Team's current onsite review, the Psychiatry Department presented compelling data that suggested the current system was functioning well, and the Facility's progress in meeting the standards of a number of the provisions of the Settlement Agreement, would tend to support this opinion. In addition, they presented time allocation data, which illustrated how the required functions of the Psychiatry Department were distributed between the full-time Psychiatrist, the Consulting Psychiatrist, the two full-time Psychiatric Nurses, and the two full-time Psychiatric Assistants. The analysis of the time distribution took into account the requirements of the Settlement Agreement. An example of this cooperation was the manner in which the Department had been able to achieve an attendance rate of 95 percent for the ISP meetings for individuals prescribed psychotropic medications over the past six months by distributing the preparation for, and attendance at, these ISPs throughout all six of the members of the Department. The above analysis was put forth in a detailed, three-page document, which appeared to be mathematically and clinically reasonable. Despite the compelling nature of the information the Psychiatry Department produced, and the substantial progress they had made with the current composition of professionals, the language of this provision of the Settlement Agreement specifically states that the professionals who provide the clinical services are required to be "Psychiatrists." At the time of the review, the Facility did not have the two full-time equivalent psychiatrists that it had determined and the Monitoring	

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		Team had agreed were necessary to support the population at CCSSLC. Thus, the Facility was not in substantial compliance with this provision, and it should also be noted that the Facility continues to have available a full-time Psychiatrist block, which they have the capability of filling, if a viable candidate were to become available.	
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 a sample of 17 individuals receiving psychotropic medication identified a CPE for all 17 (100%), and they had been completed/updated within the last 12 months. The review of the spreadsheet the Facility maintained to track the completion and annual updating of the CPEs indicated that a CPE had been completed for all of the 112 individuals prescribed psychotropic medication, including the 17 individuals mentioned above. This data also indicated that all of the CPEs had been completed within the past 12 months. A separate column in the spreadsheet indicated when the next annual update would be due. Based on review of this document, at the time of the Monitoring Team's onsite review, a CPE had been updated within the last 12 months for all of the 112 individuals receiving psychotropic medication (100%). In order to further assess the integrity of the spreadsheet, an additional sample of 11 individuals was requested during the Monitoring Team's onsite review to augment the sample selected for the record reviews. This brought the total number of CPEs reviewed to 28 of the 112 individuals (25%) receiving psychotropic medication. The CPEs of the additional 11 individuals (and the date of completion) were those of: Individual #237 (9/30/13); Individual #279 (9/18/13); Individual #273 (9/13/13); Individual #343 (9/11/13); Individual #321 (8/29/13); Individual #313 (8/23/13); Individual #225 (8/23/13); Individual #184 (8/27/13); Individual #372 (8/16/13); Individual #153 (8/16/13); and Individual #263 (8/12/13). The format and content of these documents 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 were contacted, if possible, and the	Substantial Compliance

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		individual was interviewed. 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 expanded sample of individual records, the psychiatric diagnosis for all 28 (100%) of the individuals prescribed psychotropic medication contained adequate documentation to justify the diagnosis. The Monitoring Team's previous review indicated there had been a disruption in what had been an effective mechanism for completing the CPEs in a timely manner, which was related to circumstances beyond the control of the Facility. However, the finding of substantial compliance was continued, as the Settlement Agreement allowed for exceptions in "situations that constituted a temporary failure to comply during a period of otherwise maintained compliance." The Facility had previously relied upon a locum tenens Psychiatrist to complete the CPEs. Currently, the Chief Psychiatrist completed these documents. This procedural change should decrease the possibility of future disruptions in the timely completion of these important documents. As indicated by the data provided above, this review found there was a completion rate of 100 percent for the individuals in this sample for both the quality and timely completion of the CPEs. This was also true for an additional sample of 11 individuals, which brought the total of the CPEs reviewed to 25 percent of the 112 individuals prescribed psychotropic medication at the time of the Monitoring Team's current review. Thus, the finding of substantial compliance was continued.	
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	A spreadsheet, updated on 7/22/13, 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 2013. The Facility's policy was to repeat the Reiss Screen for all 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	Substantial Compliance

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	psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	the corresponding individuals in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate. At the time of the Monitoring Team's previous review, in April 2013, 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. The date of the Reiss Screening in parentheses "( )" and the total Reiss Scores in brackets "[ ]" 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 reevaluation performed by the Department of Behavioral Services. These individuals were as follows: Individual #300, Individual #177, Individual #142, and Individual #38. The spreadsheet and 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 on 3/14/13. The narrative sections of the CPE indicated he had a diagnosis of 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 Psychiatry Department and prescribed psychotropic medication, 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 psychotropic 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 did not need to be administered to five of the six individuals admitted to CCSSLC in this timeframe. These five individuals were prescribed psychotropic medication at the time of admission. Accordingly, they were evaluated with a CPE instead of a Reiss Screen for Maladaptive Behavior. One of these six individuals (not prescribed psychotropic medication at the time of admission) was evaluated with the Reiss Screen on 8/2/13.	

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		The CPE preceded the Reiss in this situation, because the Psychiatry Department anticipated that he might need psychotropic medication. The CPE had been performed on 7/23/13. The Reiss Score for this individual was nine. This individual (i.e., Individual #27) was not currently followed in Psychiatry Clinic, because it was not felt there was an immediate need and, historically, he refused medication when it had been prescribed. Additionally, as part of the ongoing comprehensive psychological evaluations that the Department of Behavioral Services performed, the following 18 individuals had a Reiss Screening administered on the dates indicated in parentheses: Individual #177 (1/10/13); Individual #142 (2/11/12); Individual #39 (3/11/13); Individual #38 (10/1/12); Individual #343 (1/9/13); Individual #58 (11/16/12); Individual #263 (11/16/12); Individual #298 (1/10/13); Individual #315 (12/2/12); Individual #165 (1/10/13); Individual #300 (9/26/12); Individual #115 (3/26/13); Individual #153 (1/8/13); Individual #98 (4/24/13); Individual #183 (3/16/13); Individual #19 (8/15/12); Individual #159 (9/27/12); and Individual #10 (1/8/13). None of these individuals received a CPE as a result of the Reiss Screening, because they were all followed in the Psychiatric Clinic format and, thus, had been evaluated with an annual CPE related to that status. 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 Monitoring Team's 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 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	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, observations of the Psychiatric Clinics that occurred on 10/1/13 indicated that the Behavioral Health Specialist 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.	Noncompliance

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	combined assessment and case formulation.	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 Assessment and the PBSP. As indicated in Monitoring Team's 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 Behavioral Health Services 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 Section J.2 and Section 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 Behavioral Health Services Department also had developed a section in its assessment entitled: "Psychiatric Information," which described how the psychiatric disorder would affect the behavioral presentation for those individuals for whom this was relevant. This coordinated, complementary documentation was evidence of collaboration between the Psychiatry and Behavioral Health Services Departments with regard to combined case formulation. The impact of the psychiatric disorder on the individual's problematic behavior also appeared throughout the Psychology documentation where it was relevant. The integration of the behavioral data into the Psychiatry Clinic documentation is also discussed with regard to Section J.13. The Psychiatry Department's utilization of objective measurement tools is reviewed in relation to Section J.2 and Section J.13. The primary disciplines that attended the Monthly and Quarterly Psychiatric Clinics were Nursing, Psychiatry, Behavior Services, Medicine, a direct support professional, and a QIDP. 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 individual ISP meetings. The ISP meeting documentation was reviewed for the 17 individuals in this sample. This review indicated that a member of the Psychiatry Department attended the annual ISP meeting for 11 (65%) of the 17 individuals in the sample. The six individuals whose records did not contain the evidence of attendance by a member of the Psychiatry Department (date of ISP) were as follows: Individual #177 (1/13/13); Individual #202 (1/23/13); Individual #72 (4/17/13); Individual #300 (10/9/12); Individual #40 (1/16/13); and Individual #348 (10/19/12). Individual #177 and Individual #40 were missing the signature sheets in their ISP documentation. At the time of the Monitoring Team's previous review, in April 2013, the Psychiatry	

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		Department had begun an initiative to have a member of the Department attend the ISP of each individual prescribed psychotropic medication. The Department also intended to prepare the documentation representing the individual's psychiatric treatment, which would be reviewed in the ISP Preparation meeting, and then discussed in the annual ISP meeting. This documentation would be completed in conjunction with the individual's annual IRRF, which had been modified to contain a joint Behavioral Health section, as well as the Polypharmacy section, for those individuals whose medications met the criteria for polypharmacy. The Behavioral Health section represented a collaborative effort between the Psychiatry and Behavioral Health Services Departments for those individuals both disciplines served. This initiative had evolved into the development of a document entitled, "Psychoactive Medication Treatment Plan," which contained the following 13 major headings: ▪ Demographics/Brief History Statement; ▪ Psychiatric Diagnosis and Symptoms of Diagnosis: Table Axis I, II, III; ▪ Diagnosis for Axis IV and V; ▪ Target Behaviors Monitored; ▪ Psychological Assessment; ▪ Combined Behavioral Health Review/Formulation; ▪ Psychoactive Medication; ▪ Risk of Medication; ▪ Risk of Illness; ▪ Non-pharmacologic Treatment; ▪ Risk versus Benefit Discussion; ▪ Past Pharmacotherapy; and ▪ Future Plans. At the time of the April 2013 review, a member of the Monitoring Team reviewed five completed prototypes of this document. This review found that the discussion of the subject matter related to the major headings was sufficiently detailed, and taken in conjunction with the psychiatric material in the related IRRF, if completed thoroughly and accurately, would fulfill the documentation aspects of this provision, if the quality could be maintained over time. A request for a list of ISP meetings that a member of the Psychiatry Department attended from 4/1/13 through 10/2/13 showed attendance at the ISP meetings for 52 of the 55 (95%) individuals who were scheduled for an annual ISP in this timeframe. The evidence that was considered in this regard was simply whether or not the signature of a member of the Psychiatry Department appeared on the attendance sheet for that meeting. As indicated above, five of the six ISP meetings for whom there was no evidence that a member the Psychiatry Department attended were conducted before the Department began their initiative to attend all of the ISPs. The exception was Individual #72	

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		(4/17/13). On 10/2/13, members of the Monitoring Team attended the ISP meeting for Individual #92. The Psychiatrist was an active participant in this meeting, and provided a thorough review of the unique benefits of the individual's psychoactive medication as weighed against both the realized and potential side effects. For the sample of 17 individuals, there was evidence that the Psychiatric Treatment Plan was reviewed during the ISP meeting for 14 (82%) of the individuals. The specific evidence that is referred to here consisted of a specific notation in the ISP that the Psychiatric treatment plan was reviewed and discussed in the meeting. The three individuals for whom documentation could not be found to substantiate review of the Psychiatric Treatment Plan included: Individual #90 (5/23/13); Individual #202 (1/23/13); and Individual #40 (1/16/13). However, two of these pre-dated the initiative described above, which began after the Monitoring Team's April 2013 review. Within the sample of 17 individual records there were 10 individuals whose ISP occurred after the beginning of the April 2013 initiative: Individual #61 (6/10/13); Individual #304 (7/11/13); Individual #183 (6/11/13); Individual #371 (5/24/13); Individual #118 (5/2/13); Individual #90 (5/23/13); Individual #72 (4/17/13); Individual #13 (6/17/13); Individual #20 (9/19/13); and Individual #119 (8/16/13). Thus, since the Psychiatry Department began its initiative in April 2013, the necessary documentation was found in 90 percent of the ISP documentation. The exception to this was the previously mentioned ISP for Individual #90 (5/23/13), which did not contain documentation that the Psychiatric Treatment Plan was reviewed. As indicated above, the Facility's data indicated a member of the Psychiatry Department had attended 95 percent of the ISP meetings for the 55 individuals for whom there had been an ISP since the Monitoring Team's previous review in April 2013; and 90 percent of the ten ISPs in the sample of 17 individuals that had occurred since that time contained a reference indicating that the psychiatric treatment plan submitted as part of the ISP Preparation meeting documentation had been discussed during the meeting. Although this represents significant improvement, it was only true for the relatively small number of individual records that represented the post-April 2013 time frame. Thus, the finding of noncompliance was carried forward from the prior review. In addition to the small sample size, the references to the discussion of the Psychiatric Treatment Plan that appeared in the ISP documentation was minimal in nature, and it was difficult to infer from those statement how comprehensive and detailed the discussions were. Thus, the Facility will need to both maintain the initiative that was begun in April 2013 and work with the other members of the IDT to expand the material that is contained in the final ISP to include more information about the extent of the review of the material contained in the Psychiatric Medication Treatment Plan.	
J9	Commencing within six months of	As noted above with regard to Section J.8, the integration of psychiatric and psychological	Noncompliance

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	the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	behavioral services was evident in the conduct of the Psychiatric Clinics, as well as the documentation found in the sample of 17 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 Assessments and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely 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 PBSPs were developed through parallel processes that were not fully integrated. The differentiation of the problematic behaviors the individuals 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 Behavioral Health Services 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 Review 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. These more comprehensive Quarterly Review documents had been in routine use for all of the individuals prescribed psychotropic medication for a over a year. The CPEs met the quality standards of the Settlement Agreement and 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 in the Quarterly Review documentation discussed above. In addition, the Behavioral Health Services Department had added a section to their documentation entitled: "Psychiatric Information," which also addressed this issue. The Behavioral Health Services Department also included references to the influence of the individual's psychiatric disorder on their maladaptive behaviors throughout their documentation, as appropriate. Thus, the integration was more comprehensive than just a single summary paragraph. All of these methods are described in more detail with	

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		regard to Section J.8. This provision also stipulates this information should be discussed during the ISP meeting and referenced in the ISP meeting documentation. As noted with regard to Section J.8, a member of the Psychiatry Department had been able to attend 95 percent of the individuals' ISP meetings that occurred in the interval since the Monitoring Team's prior review in April 2013. In addition, the information in the PMTP and the IRRF had been completed for each of these individuals. However, as discussed above with regard to Section J.8, the information in the IRRFs and ISPs was minimal, and was not sufficient to show that: "the IDT, including the psychiatrist… determine[d] the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone." At the time of the Monitoring Team's previous review, the Facility had developed a format that appeared to fulfill the requirements of the Settlement Agreement for Section J.8 and Section J.9, but this could not be definitively determined until the actual documentation was implemented. In addition to the contributions in the documents referenced above, these subjects are specifically addressed in the PMTP and the IRRF, as described in Section J.8. As described in Section J.8, the evidence reviewed indicated that CCSSLC had been referencing this information for 90 percent of those 17 individuals in the sample who had an ISP since April 2013, but the information was not of adequate quality. The finding of noncompliance for this provision was based on the same rationale as described in the discussion related to Section J.8. Specifically, although some improvement was seen since the department began their April 2013 initiative, the sample size on which to assess this is relatively small. In addition, the references to the review of the Psychiatric Treatment Plan in the final ISP documentation were brief (often only one or two sentences), and did not include the information necessary to draw a definitive conclusion about the nature of the teams' discussions. The PMTPs completed after April 2013 included documentation related to the use of behavioral, pharmacological, or other interventions, in combination or alone, as specified in this provision of the Settlement Agreement, but teams needed to discuss this information, and document their deliberations. The IRRF is an appropriate mechanism for including the information from the Psychiatry Department in a draft, and then, prompting the teams to discuss the various interventions. The Psychiatry Department will need to work with the other members of the IDT to develop an efficient mechanism to include a description of the teams' deliberations and decisions in the final ISP documentation.	
J10	Commencing within six months of	This provision of the Settlement Agreement addresses the risk-versus-benefit	Noncompliance

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	the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	considerations related to the use of psychotropic medications for a specific individual. 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 identified as the targets of the psychotropic medication. At the time of the previous review, the Facility had responded to the recommendations contained in the Monitoring Team's initial 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. As indicated with regard to Section J.8 and Section J.9, the PMTP provided specific additional information regarding the risk-versus-benefit considerations. Beginning after April 2013, both the IRRF and the PMTP had been expanded to include more detailed information, including information regarding the potential and realized side effects, the potential and/or realized therapeutic benefits of the medication, as well as the rationale for those determinations. The PMTP (the contents of which are detailed in relation to Section J.8) also provided specific information concerning less intrusive, non-pharmacological interventions that had either been considered or implemented and found to be ineffective. All of the 17 individuals reviewed, in the sample of 15 percent of individuals prescribed psychotropic medication, contained an updated CPE (as discussed with regard to Section J.6), Quarterly Review documentation, the IRRF, and PMTP, each of which contained information related to the risk-versus-benefit consideration. In addition, 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 HRC 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 of the Monitoring Team's reviews. On 10/2/13, 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 the Monitoring Team's prior onsite reviews were also consistent with these findings. At the time of the Monitoring Team's initial review, it was noted that the thoroughness of these discussions was not always reflected in the documentation subsequently found in the record reviews. The Facility had responded to these recommendations by changing the format of the minutes generated by the meetings of the HRC, so they covered the salient aspects of the	

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		discussions in a succinct manner. The finding of noncompliance for this provision was due to the same deficits in the ISP documentation as discussed with regard to Sections J.8 and J.9. Specifically, the sample size of this documentation from the timeframe following the April 2013 effort to improve the documentation is relatively small, and more importantly, the reference to this material that is contained in the ISP was not sufficient to draw any definitive conclusions about the extent of the discussions that occurred in those meetings, the teams' deliberations, and final decisions.	
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 review of the "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" for the prior six months indicated that the Chief of Psychiatry, Consulting Psychiatrist, an Attending Physician, a member of the Behavior Services Staff, a representative from the Quality Assurance Department, a representative from the Pharmacy, and the Psychiatry Assistant regularly attended these meetings. 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 10/1/13 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 10/1/13. As per recommendations made in the Monitoring Team's previous reports, the Facility tracked the status of the individuals who were admitted from the community within the last year separately. The data for the remaining 106 individuals indicated that 14 (13%) of these individuals were receiving two or more medications from the same class, and 45 (42%) individuals were receiving three or more medications, regardless of class. Of these, 13 individuals were in both the three-or-more and the intra-class categories. The specific information regarding the number of individuals receiving multiple medications that meets the Settlement Agreement's definition of Polypharmacy was as follows: ▪ Three medications = 30 individuals; ▪ Four medications = 13 individuals; ▪ Five medications = one individual; and ▪ Six medications = one individual. Historical data from several years ago was not available for comparison. However, monthly comparative data was available from October 2010. It should be noted that individuals who were prescribed three or more psychotropic medications and also met	Substantial Compliance

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		the criteria for intra-class polypharmacy (as two of these medications are from the same class) were only counted once. Tabular representation of that data is as follows:	

DEFINITIONS OF POLYPHARMACY	OCTOBER 2010	SEPTEMBER 2013*
Number of individuals receiving two or more meds from the same class	37	14
Number of individuals receiving three or more meds regardless of class or indication	81	45
Total number of individuals on polypharmacy	81	46
Total number of individuals receiving psychotropic medication	145	106*
Percentage patient population receiving psychotropic medication whose medications met the criteria for polypharmacy	56%	43%

*These numbers did not include the six individuals who were admitted in the previous 12 months.

This provision of the Settlement Agreement also stated that 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 many of these medications were essential for the individuals' stability. This belief also was reflected in the minutes of the monthly Psychiatric Polypharmacy Reduction Committee Meetings. Subsequent to the Monitoring Team's prior reviews, the Facility had implemented the recommendations to develop a categorical approach in order to clinically justify and/or systematically pursue reductions in an individual's medications. Two primary categories were derived from these clinical principles. Currently, the categories utilized included the following: individuals who were admitted within the last year and were prescribed psychotropic medication (six, including two of whom had been admitted in the last 60 days); those who were in the "Active" category (eight); and those who were in the "Stable" category (N=38). The "Active" category referred to those individuals who were so clinically

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		complex that they still required active review on a monthly basis. The "Stable" category represented those individuals who were considered to be clinically stable at the time of the review, and the Psychiatry Department believed their current medications could be justified by the historical information and/or their clinical fragility, in that their status was such that a change in the dosage of medication to establish empirical justification would be considered too risky. As noted above, the Facility tracked, as a separate category, those individuals admitted from the community and prescribed multiple psychotropic medications. At the time of the Monitoring Team's onsite review, that group included six individuals. Two of these individuals were admitted to CCSSLC within the last 60 days. These individuals continue to be admitted from the community on multiple psychotropic medications, which the Facility gradually begins to decrease after the individual has had time to adjust to their new environment. The analysis of the categories above indicated that the Facility's overall rate of polypharmacy was 43% (46 of 106), excluding those individuals who had been admitted to the Facility within the last year. CCSSLC placed eight (8% of the total prescribed psychotropic medication) of these individuals in the "Active" group who were not considered to be clinically stable, and whose medications required frequent adjustments; and the remaining 38 (36%) represented those individuals for whom they felt their multiple psychotropic medications could be "justified," according to the rationale described above. The Polypharmacy Committee previously reviewed five individuals in depth every month. This methodology had been implemented in September 2012. Beginning in the April-to-May 2013 time period, CCSSLC embarked on a new initiative, involving an intensive review of each individual who met the criteria for polypharmacy. The goal was to determine if there was sufficient clinical and historical data to make a decision as to whether their psychotropic medications could be clinically justified, or if they continued to require ongoing frequent adjustments in their psychotropic medications. This process involved an intensive review of the historical records, as well as research into the archival records, as normally only one to two years of historical data was carried forward in the individual's active record. In order to provide this longer historical perspective, the Psychiatric Nurses compiled information concerning several years of historical data for the 38 individuals the Facility had placed in their "Stable" category. The result of this labor-intensive endeavor was a spreadsheet containing 62 pages of detailed historical information. It described the reasons for past changes in an individual's psychotropic medication, as well as the rationale for the current medications prescribed. A member of the Monitoring Team performed a preliminary review of the 62 pages of	

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		documentation concerning these individuals with a Psychiatric Nurse during the onsite review. Following the onsite review, another more intensive review of this documentation was conducted. The second, in-depth review found the information was sufficient to substantiate the efficacy of these medications for 35 of these individuals. The three individuals for whom the final review differed from that of the Facility's determination were: Individual #372, Individual #218, and Individual #158. The clinical complexity of these individuals was not in question. However, there had been so many changes in their medication that it was difficult to form definitive conclusions concerning efficacy, and it appeared that they would be more appropriately placed in the "Active" category. This review also found that two individuals were incorrectly classified as receiving psychotropic medication regimens that met the criteria for polypharmacy. These individuals were (medications prescribed): Individual #174 (Seroquel, Aricept, and Namenda); and Individual #326 (Fanapt, Aricept, and Trazodone). The documentation for these individuals clearly indicated that, for these individuals, the Aricept and/or Namenda were being prescribed for a cognitive decline related to dementia, which is an approved use of these medications, as a medical/neurological intervention, rather than as a treatment for a psychiatric disorder. The changes in classification described above would change the number of individuals in the "Active" category to 11, and decrease the number in the "Stable" polypharmacy group to 33, as three were moved to the "Active" category, and two were deleted from the Polypharmacy List. The resulting number of individuals in the unjustified "Active" polypharmacy group for the 106 individuals (excluding the six individuals admitted during the prior 12 months) receiving psychotropic medication at CCSSLC would then be 10 percent. The Facility was found to be in substantial compliance with this provision, as this is an acceptable rate of polypharmacy, given the clinical complexity of the individuals who resided at the Facility.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	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 DISCUS, and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES 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. The review of the sample of the records of 17 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 was present for all of the individuals in this sample (100%). The Facility performed the MOSES evaluations every three months, rather than six months, so that this evaluation would coincide with the	Substantial Compliance

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		DISCUS. The Facility's rationale for doing this was that linking the two together would simplify the process and, thus, increase the completion rate. This was not, however, a requirement for substantial compliance. The records of the 17 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 16 of the 17 (94%) individuals. The one individual for whom documentation of the review by the prescriber was inadequate was Individual #118, because the second (signature page) from the 7/8/13 MOSES evaluation was missing for this individual. Thus, there was insufficient documentation to confirm that the MOSES evaluation was reviewed in a timely manner. 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 the 17 individuals in the sample indicated that only 15 of these individuals were prescribed antipsychotic agents that would require monitoring with the DISCUS. The two individuals who were not prescribed antipsychotic medication that would require monitoring with the DISCUS were Individual #183 and Individual #202. The documentation contained in the records of the remaining 15 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 evaluation and whether or not additional action was required. Each Quarterly Review contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES were 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 psychiatric medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan, as well as an 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	

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		evaluations for these individuals, rather than the Psychiatric Nurses. This process indicated that, as of 10/1/13, ten individuals receiving Reglan were not also prescribed medication for a psychiatric disorder. The following sample of four (40%) individuals who fit the above criteria was selected, and included: Individual #43, Individual #270, Individual #266, and Individual #189. 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 all (100%) of the individuals in this sample. All (100%) of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner. 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 all of the four (100%) individuals. The documentation indicated that the prescribing physician had reviewed all (100%) of these evaluations in a timely manner. In reviewing this documentation, it became evident that there were periods of time during which both the MOSES and DISCUS had been performed monthly, and, in general, the frequency of the reviews exceeded the requirements set forth in the Settlement Agreement. During the onsite review, a member of the Monitoring Team also inquired about the degree of training the Residential 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 a 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 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 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 Residential Nurses were receiving adequate training to competently complete the DISCUS evaluations for those individuals prescribed Reglan. The MOSES evaluation material included 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	

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		that the DISCUS was completed as required and reviewed in a timely manner for 100 percent of the individuals prescribed antipsychotic medication contained in the sample of 15 individuals, as well as the four individuals in the Reglan sample. In addition, the MOSES had been completed in a timely manner for all of the 17 individuals in the sample who were prescribed psychotropic medication, as well as the four individuals prescribed Reglan. All evaluations had been reviewed in a timely manner, with the exception of one evaluation for one individual in the general sample, for whom the second (signature page) was missing.	
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 that are 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 17 individuals (15 percent of the total receiving 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, as did the Quarterly Psychiatric Reviews. Each individual record also contained a "DSM-IV-TR Diagnostic Checklist," which verified that the diagnosis of record for that individual met the specific diagnostic criteria for each Axis I and/or Axis II diagnoses. These Checklists had been developed and implemented at the time of the Monitoring Team's prior review. In addition, in the Monitoring Team's previous reports, a discussion was 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 initially responded to this by developing a psychiatric symptoms tracking scale. It defined 21 symptoms that related to the Major Axis I psychiatric diagnosis. As discussed with regard to Section J.2, this instrument had evolved into a more concise scale that consisted of the following eight categories of symptoms: 1. Mood disturbance (Depression/Mania/Hypomania); 2. Psychosis (Hallucinations/Delusions/Paranoia); 3. Obsessive Compulsive Disorder (OCD) symptoms; 4. Sleep disturbances (Insomnia/Hypersomnia); 5. Attention Deficit Hyperactivity Disorder (ADHD) symptoms (Inattention/Hyperactivity/Impulsive); 6. Impulsive/Aggression to self or others [Self-injurious Behavior (SIB)/Pica, etc.];	Substantial Compliance

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		7. Suicidal/homicidal ideations; and 8. Anxiety. Previously, the Residential Nurses completed these ratings for the symptoms specific to the individual, as determined by the Consulting Psychiatrist and the other members of the interdisciplinary Psychiatric Clinic teams. The QA/QI Committee was currently reviewing the new format and, when approved, the discussions would occur in the Quarterly Psychiatry Clinics, and would, thus, include the IDT members that routinely attend those meetings. 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 diagnoses 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 Section J.8 and Section J.9, observation of the 10/1/13 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. Beginning in September 2013, the Psychiatry Department also had added a section to the Quarterly Review documentation related to the risk-versus-benefit considerations. In addition, beginning in April 2013, the PMTP described in relation to Section J.8 had been completed for all of the individuals prescribed psychotropic medication. 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." In addition, a requirement of this provision of the Settlement Agreement relates to the Facility's ability to develop and maintain data collection methods sufficient to determine if the medications being utilized were effective. These "symptoms or behavioral characteristics" were now effectively identified through the methods described above and reviewed in detail with regard to Section J.2. In addition, the relationship between the psychiatric disorder and the behaviors that Behavior Services staff addressed were clarified in the Bio-Psycho-Social-Spiritual formulation of the CPE, the Quarterly Psychiatric Review Notes, and the Psychiatric Information section of the PBSP. The symptoms of the psychiatric disorder for which the psychotropic medication was prescribed also were monitored to assess the efficacy of the medication through the information brought to the clinics and reviewed by the clinic teams. As indicated with regard to Section J.11, the Psychiatry Department also had developed a major initiative to compile the psychiatric documentation necessary to	

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		document the efficacy of multiple psychotropic medications for those who required polypharmacy to maintain their stability. The specific language in this provision that addresses this issue is as follows: "…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…." As indicated in the comments above and in the narrative discussion related to Section J.11, CCSSLC had developed methods to assess the efficacy of the psychotropic medications, both through the Quarterly Review documentation and the deliberations of the Monthly Polypharmacy Committee Meetings. The Quarterly Psychiatric Review documentation identified 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, because the medications already 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 Behavior Services Progress Notes routinely carried forward several months of behavioral data. As indicated in the Monitoring Team's previous report, the determination of the efficacy of psychotropic medications would have benefitted 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 BSP as they corresponded with changes in the frequency of the monitored behavior, would greatly enhance the utility of this information and provide the additional historical data points with which to make comparisons with current frequencies. This additional data would then enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be effective from an empirical perspective. The Psychiatry Department responded to these recommendations by undertaking an intensive review of the long-term, longitudinal pharmacological history for those individuals who met the criteria for polypharmacy. This process, which is described in	

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		more detail with regard to Section J.11, involved the Psychiatric Nurses reviewing information from the individuals' archival records, which in some instances, dated back several years. This information indicated that for the majority of individuals prescribed multiple psychotropic medications, the use of those medications could be justified. 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 Behavioral Health Specialists to monitor the frequency of the other behaviors presented in the Psychiatric Clinic notes. These behaviors would primarily be those derived from the symptoms of the psychiatric disorder and/or those determined by both psychiatric and behavioral factors. Direct support professionals collected the actual raw data for these behaviors under the direction of the Behavioral Health Specialist 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. 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 17 (100%) individuals, both in terms of timeliness, as well as the quality of the documentation and its responsiveness to each of the requirements. 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 Residential RN Case Manager, and a direct support professional usually attended the Psychiatric Clinics. The Facility was found to be in substantial compliance with this provision, as their completion rate for each of the multiple requirements of this provision was 100 percent, based on the review of individual records and related relevant documentation, as described above.	
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	The review of the Rights/Consents section of the medical records for the sample of 17 individuals indicated that five (29%) individuals 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 17 (100%) individuals in the sample. At the time of the Monitoring Team's prior reviews, CCSSLC had implemented a number of measures to improve the risk-benefit analysis, as well as the quality of the information	Substantial Compliance

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	consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	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. This material was consistent with accepted standards for this type of information, and provided both a reasonable description of the potential risks of the medication as well as the potential benefits. In addition, the Facility had implemented an initiative to replace the practice of obtaining consents and HRC 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 also was mirrored in the HRC's review process, in that the HRC review approval process now addressed each medication as a separate entity. These processes had been fully implemented for several months. An important component of the Facility's plan to address these issues also involved a change to the consent process. Rather than having the individual's Behavioral Health Specialist 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 substantial compliance for this provision of the Settlement Agreement was related to the significant improvement in the risk-versus-benefit discussions, which were now present in all of the individual records reviewed and the evidence that informed consent had also been obtained for the use of these 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	The Monitoring Team's initial reports identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist for individuals prescribed psychotropic medication to treat seizures and mental health disorders. 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	Substantial Compliance

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	are prescribed to treat both seizures and a mental health disorder.	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. In order to assess the efficacy of this process, the Neurology section of the records of the 17 individuals in the review sample were requested. Review of this documentation indicated that the Consulting Neurologist had provided consultation for the following four (24%) individuals within the last 12 months: Individual #304, Individual #20, Individual #119, and Individual #300. Reference to the most recent Neurology Consultation was located in the Psychiatric Clinic Notes for all four (100%) of these individuals. The most recent Neurology Notes also contained a reference to their psychiatric status and medications. In order to increase the size of this sample to make the review more reliable, nine individuals were chosen from the spreadsheet the Facility maintained to track the occurrence of Neurology Consults for the individuals also prescribed psychotropic medication. This represented all of the individuals jointly followed by the Psychiatry and Neurology Departments who had been seen at the 8/24/13 Neurology Clinic. This date was chosen, as enough time had elapsed since the Neurology Consultation, that it would have been reviewed in a subsequent Psychiatric Quarterly or Monthly Review. The nine individuals selected, the date of the Neurology Consultation, and the subsequent Psychiatric Review dates were as follows: **INDIVIDUAL** / **NEUROLOGY CONSULTATION** / **PSYCHIATRIC REVIEW** Individual #44 / 8/24/13 / 9/17/13 Individual #119 / 8/24/13 / 9/17/13 Individual #20 / 8/24/13 / 9/13/13 Individual #305 / 8/24/13 / 9/13/13 Individual #157 / 8/24/13 / 9/17/13 Individual #376 / 8/24/13 / 8/27/13 Individual #115 / 8/24/13 / 9/17/13 Individual #236 / 8/24/13 / 9/13/13 Individual #33 / 8/24/13 / 9/13/13 This documentation confirmed that the Neurology Consultation Notes contained the relevant information concerning the individual's psychiatric treatment for eight of the	

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		nine (89%) individuals listed above. The record of Individual #236 did not contain any mention of the individual's psychiatric status in the Neurology Note. The Neurology Consultation was both acknowledged and briefly summarized in the corresponding Psychiatric Review Note for all nine individuals (100%). 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 were 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 necessary 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 current finding of substantial compliance is based on the finding that the Neurology Note contained adequate reference to the individual's psychiatric status in 12 of the 13 (92%) individual records reviewed from the sample. In addition, the Psychiatric Clinic Note prepared after the Neurology Consult provided a succinct overview of the corresponding Neurological Consultation. At the time of the onsite review, a member of the Monitoring Team discussed with members of the Psychiatric Department the language that narrows the scope of this section to the joint coordination of medications "when they are prescribed to treat both seizures and a mental health disorder." The department members responded that they intended to continue the monitoring of the clinical coordination of all of the individuals who are followed by both disciplines, even though this exceeds the requirements of the Settlement Agreement. At the time of the Monitoring Team's previous review, this provision was found to be noncompliant, due to deficits in Neurology Consultation Notes that did not reference the individual's psychiatric treatment. During the current onsite review, the Chief Psychiatrist indicated that she had met with the Neurologist to stress the importance of the coordination between the two disciplines, following that review. The Psychiatry Department will need to ensure that the consistency in documentation is continued in order to maintain compliance with this provision.	

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 Online job profiles for: 1) Psychologist III – Chief Psychologist; and 2) Psychologist II – Assistant Chief Psychologist; o Behavior Support Committee (BSC) and external peer review meeting minutes, as available, dated 3/6/13 through 7/31/13, and 2/8/13 through 7/26/13, respectively; o For Section K.4, Positive Behavior Support Plans (PBSP) and PBSP Monthly Progress Notes, as provided, for: Individual #19, Individual #234, Individual #318, Individual #118, Individual #353, Individual #16, Individual #61, and Individual #9; o For Section K.4, Crisis Intervention Plans (CIP) and PBSP Monthly Progress Notes, as provided, for: Individual #40, Individual #253, and Individual #238; o For Section K.4, raw behavior data sheets, as provided, for: Individual #326, Individual #9, Individual #61, Individual #97, Individual #269, Individual #367, Individual #353, Individual #16, Individual #13, Individual #46, Individual #305, and Individual #290; o For Section K.4, Monthly Psychiatric Reviews for the months of May to July 2013, as available, for: Individual #318, Individual #61, Individual #9, Individual #326, Individual #305, Individual #46, Individual #367, Individual #353, Individual #290, Individual #13, Individual #269, Individual #16, Individual #183, and Individual #97; o For Section K.5, Comprehensive Psychological Assessments, as available, for: Individual #138, Individual #19, Individual #318, Individual #118, Individual #371, Individual #253, Individual #386, and Individual #234; o For Section K.6, Psychological Assessments, Psychological Evaluation/Updates, or Comprehensive Psychological Assessments, and Inventory for Client and Agency Planning (ICAP), as available, for: Individual #238, Individual #138, Individual #137, Individual #19, Individual #40, Individual #318, Individual #98, Individual #93, Individual #118, Individual #371, Individual #198, Individual #253, Individual #368, Individual #234, Individual #61, Individual #9, Individual #326, Individual #305, Individual #46, Individual #367, Individual #353, and Individual #290; o For Section K.7, Psychological Assessments or Comprehensive Psychological Assessments, as available, for: Individual #17, Individual #35, Individual #39, Individual #98, Individual #27, Individual #115, and Individual #33; o For Section K.8, Counseling Treatment Plans, Monthly Counseling Reviews, and a Summary Listing of Individual Contract Treatment Goals, as provided, for: Individual #253, Individual #7, Individual #118, Individual #55, Individual #98, Individual #97, Individual #191, Individual #275, Individual #297, and Individual #172; o For Section K.9, Positive Behavior Support Plans for: Individual #19, Individual #234, Individual #318, Individual #118, Individual #353, Individual #16, Individual #61, and

	Individual #9; o For Section K.9, onsite review of consents (e.g., BSC, guardian, and/or Director) related to PBSPs approval and review, as available for: Individual #238, Individual #318, Individual #118, Individual #138, and Individual #371; o Inter-observer agreement (IOA) and Reliability Check Spreadsheets (TX-CC1309-PH4), provided 10/2/13; o For Section K.10, Positive Behavior Support Plans and PBSP Monthly Progress Notes, as provided, for: Individual #238, Individual #138, Individual #19, Individual #40, Individual #318, Individual #98, Individual #118, Individual #371, Individual #198, Individual #253, Individual #368, and Individual #234; and o For Section K.11, Positive Behavior Support Plans and readability estimates, as provided, for: Individual #238, Individual #138, Individual #19, Individual #40, Individual #318, Individual #98, Individual #118, Individual #371, Individual #198, Individual #253, Individual #368, and Individual #234. ▪ **Interviews and Meetings with**: o Section K review with Judy Sutton, M.S., LPC, Board Certified Behavior Analyst (BCBA), on 9/30/13 and 10/1/13; o Section F review with Rachel Martinez, on 10/1/13; o Section S review with Kimberly Benedict, on 10/1/13 and 10/2/13; o Section C review with Judy Sutton, M.S., BCBA, on 10/2/13; o Meeting with QA/QI and Section K Program Compliance Monitors, including Judy Sutton, M.S., LPC, BCBA, and Karen Ryder, QA/Program Compliance Monitor, on 10/2/13; o Phone conversation with Judy Sutton, M.S., LPC, BCBA, on 10/9/13; and o Phone conversation with Kristina Sheets, Director of Residential Programming, on 10/9/13. ▪ **Observations Conducted**: o Observation and discussion at the Restraint Reduction Committee meeting, on 9/30/13; o Observation and discussion at the Vocational Career Fair, on 9/30/13; o Observation and discussion at the Skill Acquisition Committee meeting, on 10/1/13; o Observation and discussion at the Desensitization Committee meeting, on 10/2/13; o Observation and discussion at the Restrictive Practices Committee, on 10/2/13; o Onsite direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or afternoon hours at the following residential and day programming, and habilitation sites: ▪ Apartment 522B (Kingfish 2), on 9/30/13 and 10/3/13; ▪ Apartment 522 C (Kingfish 3), on 9/30/13; ▪ Apartment 522D (Kingfish 4), on 9/30/13; ▪ Apartment 524D (Ribbonfish 4), on 10/1/13; ▪ Apartment 524B (Ribbonfish 2), on 10/1/13; ▪ Apartment 524A (Ribbonfish 1), on 10/1/13; ▪ Apartment 524C (Ribbonfish 3), on 10/1/13; ▪ Horizons, on 10/3/13;

	▪ Kaleidoscope, on 10/3/13; ▪ Apartment 522A (Kingfish 1), on 10/3/13; and ▪ Apartment 514 (Dolphin), on 10/3/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K, dated 9/13/13. 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. Sixteen completed rubrics scored for eight individuals across two raters were provided for review. Verbal reports at the time of the Monitoring Team's visit and provided documentation indicated that approximately four monitoring tools (two of each rubric) were completed each month and that raters met regularly to discuss the ongoing monitoring. It should be noted that overall average of 99% agreement was reported in the Self-Assessment for tools completed between 2/1/13 and 7/31/13. This estimate was higher than expected given the lower correspondence found across several of the examples provided for review. Discussions during the onsite visit also indicated that this monitoring had not changed significantly since the Monitoring Team's last visit. ▪ 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, PBSPs, readability estimates, 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.11. These ratings were not consistent with the Monitoring Team's current findings.
	Summary of Monitor's Assessment: Behavioral Health Services Providers 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. However, despite this progress, recent changes within the leadership of the department significantly changed the provision of

	services by BCBAs. That is, at the time of the visit, the top two leadership positions within the Behavioral Health Services Department were vacant and no clinical supervision was in place for the members of the Behavioral Health Services Department. Since the Monitoring Team's last visit, progress was not conspicuous in the area of internal peer review within Behavioral Health Services Department. However, some progress was noted in the area of external peer review. Progress continued to be observed in the completion of psychological assessments, including the completion of standardized tests of intelligence and tests of adaptive behavior as well as in the increasing use of the comprehensive psychological evaluation format. However, concerns were noted with the completion of assessments for newly admitted individuals. Progress continued to be evident in the area of data collection and ongoing progress monitoring, including data display. Although progress was noted, concerns about the adequacy of data collection, including its flexibility and timeliness as well as reliability remained. Efforts were noted with regard to the development of improved PBSPs. However, concerns regarding the adequacy of staff instructions, receipt of consent, and timeliness of implementation were noted. In addition, concerns were noted with regard to the provision of services to individuals requiring psychological services other than PBSPs, including the provision of counseling services.

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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	Since the Monitoring Team's last visit, Behavioral Health Services Providers 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. However, despite this progress, recent changes within the leadership of the department significantly changed the provision of services by BCBAs. As noted in the Monitoring Team's previous report, at the time of the last onsite review, there were three staff members within the Behavioral Health Services Department, including the Chief Psychologist/Director and Assistant Chief Psychologist, who were BCBAs. At that time, the Chief Psychologist did not carry a caseload. Consequently, only two BCBAs were currently writing PBSPs. At the time of the current onsite review, two of the three BCBAs, including the Chief Psychologist (Director) and Assistant Chief Psychologist (Assistant Director) had resigned their positions. More specifically, the Assistant Director had resigned his position and left the Facility on June 26, 2013, and although the former Director recently	Noncompliance

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	restraint.	had resigned her leadership position on September 1, 2013, she remained within a non-administrative position within the Department and continued to act as the Section K lead. However, verbal reports indicated that she planned to discontinue her employment with the Facility the week following the Monitoring Team's onsite visit. Consequently, the Behavioral Health Services Department only had one BCBA carrying a caseload at the time of the onsite visit. At the time of the Monitoring Team's current visit, verbal reports indicated that three staff recently had completed all coursework and supervision requirements, and that two of the three staff recently had taken the BCBA exam and were waiting for their results. In addition, verbal reports and documentation indicated that three other psychologists currently were enrolled in coursework and receiving supervision. As reported in the Monitoring Team's last report, several psychologists remained reluctant to pursue certification. That is, three psychologists within the department continued to indicate that they would not pursue certification. These were the same three staff noted in the Monitoring Team's previous report. According to verbal reports and documentation, at this time, the Facility was only requiring these staff to perform additional responsibilities in lieu of pursuing additional professional competencies. Verbal reports and provided sample documentation indicated that only one contracted BCBA consultant was providing supervision. The Facility continues to be in noncompliance with this provision, 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 one member within the Behavioral Health Services Department was a BCBA. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to support psychologists in their successful completion of required academic coursework, as well as continue to ensure required supervision according to the Behavior Analyst Certification Board (BACB) eligibility guidelines.	
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	As previously reported with regard to Section K.1 of the Settlement Agreement, the Chief Psychologist (Director) and Assistant Chief Psychologist (Assistant Director), both of whom were BCBAs, resigned their positions. Consequently, the top two leadership positions within the Behavioral Health Services Department were vacant. As noted, these two professionals were two of the three psychologists within the department who	Noncompliance

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	who is responsible for maintaining a consistent level of psychological care throughout the Facility.	were BCBAs. Due to the absence of leadership within the Department, the administrative oversight of the psychologists had been temporarily transferred to the Unit Directors. This reflected the re-introduction of a supervisory model that was previously in place. Based on interview with the Facility Director and Assistant Director of Programs, at the time of the review, a qualified person to provide clinical supervision to the staff in the Behavioral Health Services Department had not been identified. Given the significant absence of leadership within the Department as well as several other unfilled positions, the Monitoring Team questioned the Facility's ability to maintain a consistent level of psychological care throughout the Facility at this time. It was noted that the Facility was actively searching for candidates for the Director and Assistant Director open positions. However, emphasis on finding certified candidates (i.e., BCBAs) appeared to be initially overlooked. That is, the online job postings for the Chief Psychologist did not identify that the candidate(s) be a BCBA or BCBA-eligible. Given that the former Chief Psychologist/Director had taken on a non-supervisory role a month prior to the Monitoring Team's onsite review, and at the time of the review, no clinical supervision was in place for the members of the Behavioral Health Services Department, the Facility was found to be in noncompliance with this provision.	
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, progress was not conspicuous in the area of internal peer review within Behavioral Health Services Department. However, some progress was noted in the area of external peer review. As described in Monitoring Team's previous reports, internal peer review of behavioral health services was provided through the Behavior Support Committee. Past reports noted substantial variability in the BSC meeting schedule that made estimation of adherence to an expected schedule challenging. At that time, BSC met at a minimum of at least once and as often as twice a week. As reported in the Monitoring Team's last report, based on previous BSC meeting minutes (between 10/1/12 and 2/27/13), it was estimated that the BSC met for 63% of scheduled meetings, based on the minimal expectation that BSC met once a week. Currently, the Monitoring Team continued with the expectation that the BSC was scheduled to meet weekly for internal peer review, with the exceptions of holidays. Consequently, given the time period of 3/6/13 through 7/31/13, it was expected that the BSC should have met approximately 21 weeks (not including the holiday on 6/19/13). It should be noted that BSC meeting minutes, if available, were not provided for review for eight weeks during this time period (i.e., meeting minutes were not available for the weeks of 3/20, 3/27, 4/3, 4/17, 5/8, 5/15, 5/29, and 6/5). Consequently, based on the provided documentation, it appeared that the BSC met in 12 (57%) out of 21 possible	Noncompliance

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		weeks. That is, it appeared that the BSC meeting(s) was either cancelled (i.e., 3/13/13) or weekly meeting minutes were not provided as evidence that the meeting occurred. If a "paper review" was held in place of BSC (as described in the Monitoring Team's previous report), evidence of this supplemental review was not provided. It should be noted that documentation provided in the Section K Presentation Book (i.e., evidence found in K.3.2) indicated that BSC meetings were not scheduled weekly. It was unclear to the Monitoring Team why the schedule of BSC meetings continued to vary so significantly from month to month given the previously noted expectation. Based on the evidence provided (i.e., minutes from 12 BSC meetings), it appeared that the Director and Assistant Director, both BCBAs, were in attendance in 50% and 58% of meetings, respectively. In addition, it appeared that a third BCBA (i.e., Associate Psychologist), the newest to receive board certification, was in attendance in 92% of the meetings. More specifically, at least one BCBA or two-or-more BCBAs were in attendance in 100% and 67% of the meetings, respectively. In addition, one-or-more Associate Psychologist and one-or-more Psychology Assistant were in attendance in 100% and 92% of the meetings, respectively. Overall, attendance over 75% was consistently found for the most recently board certified Associate Psychologist, other non-BCBA Associate Psychologists, and Psychology Assistants. These estimates reflected a substantial decline in attendance by the Director and Assistant Director compared to previously reported estimates. The Monitoring Team's previous report noted that the composition of internal peer review had changed. That is, professionals external to the Behavioral Health Services Department (i.e., nursing, psychiatry, speech language pathologists, administration, etc.) would no longer be required to attend the BSC meeting. However, these professional as well as others (e.g., QA/QI, contracted community-based BCBAs and contracted counselors, etc.) would still be welcome when their schedules permitted attendance. Although these changes were reported at the Monitoring Team's last visit, the meeting minutes continued to track the attendance of professionals both within and external to the Facility across multiple disciplines. Currently, based on the 12 BSC meeting minutes provided for review, estimated attendance percentages at meetings by one or more speech language pathologists (42%), psychiatric staff (50%), QA/QI (25%), nursing (25%), contracted counselor (0%) or contracted BCBA (0%), and Facility Administration staff, including the Director of the Facility, the Assistant Director of Programming, Residential Director, and/or Unit Director (83%) continued to vary across disciplines. Overall, although not required (per previous reports), these estimates reflected a decline in attendance by contracted BCBAs, contracted counselors and nursing staff, as well as an improvement in attendance by psychiatry and Facility Administration staff. Closer inspection of the 12 available BSC meeting minutes reflected a surprisingly low	

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		number of documents presented for internal peer review. That is, based on minutes from 3/6/13 through 7/31/13, approximately twelve individual psychological evaluations, two individual PBSPs, and one individual CIP were reviewed. It was unclear to the Monitoring Team how required BSC approval, including adequate peer review, was obtained for the other documents given this low rate (over a five-month period). That is, additional documentation as evidence of supplemental BSC and/or internal peer review was not provided. Going forward, the Facility is encouraged to document all other supplemental reviews that support ongoing internal peer review. According to the Monitoring Team's previous reports, in January 2012, external peer review at CCSSLC was initiated, and over time included the participation of professionals from other Texas State Supported Living Centers, including Abilene State Supported Living Center (ABSSLC), Austin State Supported Living Center (AUSSLC), and Lubbock State Supported Living Center (LBSSLC). As previously noted, the purpose of the external review process is for independent (external) experts to review behavioral programming and provide feedback and recommendations. It was expected that this process would occur at least once a month and include review of one or more cases from CCSSLC at each meeting. As previously reported, based on documentation provided on the external peer review process conducted between May 2012 and January 2013, the Monitoring Team found the nature of the Facility's external review process to be inadequate. More specifically, at the time of the Monitoring Team's last review, the external peer review process was inconsistent and omitted cases specific to CCSSLC. In an effort to examine the current nature of external peer review, documentation provided of this process was reviewed. This included the review of the schedule of external peer review (including review responsibilities of each Facility) as well as evidence of meetings between February and July 2013, including "External Peer Review Minutes" (from 2/8/13 and 3/6/13) and "Draft Cover Sheets for External Peer Review" (from 4/12/13, 5/10/13, 6/14/13, and 7/26/13). Although documentation appeared to support improved consistency in meeting (i.e., monthly meetings were consistently held), concerns were noted with regard to the nature of the review. For example, although LBSSLC was scheduled to review documentation specific to CCSSLC on 3/6/13, it was not conspicuous from documentation that experts from that Facility were in attendance. It should be noted, however, that experts from other Facilities were in attendance. Nonetheless, the overall external review process appeared to include assigning experts specific dates on which they would review the submitted documents from another identified facility. Consequently, it was unclear which experts reviewed the submitted documents from CCSSLC, when experts from LBSSLC were scheduled, but appeared unavailable. Overall, based on analysis of provided documentation, the	

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		reviews did not appear to be based on a standardized format. That is, the documentation reflected inconsistent content over time, leading the Monitoring Team to question the content of the review. That is, the format used to document meeting minutes changed over time. This change made it difficult for the Monitoring Team to consistently evaluate the quality of the review. For example, external reviewers were not identified on documentation for one review (on 6/14/13), operational definitions were not provided for four of the reviews (exception was on 6/14/13), data was not provided for three of the reviews (exceptions included 3/6/13, 6/14/13, and 7/26/13), and recommendations were not provided for one of the reviews (on 7/26/13). Subsequently, to move in the direction of substantial compliance, the Facility should implement a more standardized, consistent approach to external peer review, including data review, data based decision-making, and clear recommendations. In the past, the Facility indicated that the identification of individuals required to attend BSC would be noted in revised policy. At the current time, the former Director of Behavior Health Services indicated that the policy was still "a work in progress." Consequently, specification of the nature of internal and external peer review (e.g., who was required to attend) was still not explicitly stated. Consequently, the Facility will need to ensure that current procedures are specifically reflected in policy. Based on the concerns noted above, the Facility continued to be in noncompliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to ensure adherence to the BSC weekly schedule in an effort to facilitate adequate peer review and oversight of behavioral programming. The Facility also should consider explicitly identifying those professionals who are required to attend BSC within current policy. In addition, if a supplemental review process is in place to approve psychological assessments or positive behavior support plans, this process also should be explicitly identified within current policy. Lastly, the Monitoring Team recommends a standardized process for reviewing and documenting the external review process.	
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	Since the last review, progress continued to be evident in the area of data collection and ongoing progress monitoring. Although progress was noted, concerns about the adequacy of data collection, including its flexibility and timeliness, 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 eight PBSPs and corresponding monthly PBSP progress notes were selected and reviewed. This sample included individuals who had an ISP meeting since the Monitoring Team's last visit. In addition, the sample contained four individuals who were randomly selected at the time of the onsite visit, as well as four individuals who the Facility selected for	Noncompliance

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	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.	inclusion in the pre-visit document request. Current summary documentation (i.e., "CCSSLC: Individuals with PBSP," dated 8/23/13) indicated that there were 117 individuals with PBSPs. It also was reported (TX-CC-1309-PH3) that 30 PBSPs were updated since the last Monitoring Team visit. Consequently, this sample reflected approximately 7% of the total number of PBSPs (N=117) currently in place and 27% of those completed since the Monitoring Team's last visit (N=30). This review included the examination of the current PBSPs as well as one PBSP monthly note selected from documents provided for each individual sampled, as available. Review of provided documentation indicated: ▪ Eight (100%) had one or more monthly PBSP progress notes; ▪ At least one target behavior and at least one replacement behavior were displayed in monthly progress notes for eight (100%) of the individuals sampled; ▪ Target and replacement behaviors displayed in monthly progress notes were consistent with the PBSP notes for three (38%) and four (50%), respectively, of the individuals sampled; ▪ Graphic displays of one or more target behavior(s) were evident in eight (100%) of the individuals sampled; ▪ Graphic displays of one or more replacement behavior(s) were evident in eight (100%) of the individuals sampled; ▪ Current display allowed the individual analysis of target and replacement behaviors in all (100%) graphs reviewed; ▪ Medications were displayed in table format for eight (100%) individuals; ▪ Monthly notes appeared to contain appropriate data (e.g., data up through July was displayed in the July progress note) in eight (100%) of the individuals sampled; ▪ Inter-observer agreement (IOA), including data, were reported in one or more of the monthly notes for four (50%) of the individuals sampled; ▪ Although the same vague description regarding treatment integrity was found in the notes for all eight (100%) individuals sampled, data was only presented in two (25%) of the notes reviewed; ▪ Monthly notes appeared to be completed in a timely fashion for only three (38%) of the individuals sampled. Exceptions included those that appeared to be completed in excess of four (or more) weeks after the specific month targeted by the note (e.g., August monthly progress notes that were completed in October for Individual #19, Individual #234, Individual #318, and Individual #118, as well as July monthly progress note that was not dated for Individual #9); Overall, continued improvement in the quality of the monthly notes was observed. However, consistency between the monthly notes and PBSPs with regard to target and replacement behaviors (i.e., those behaviors that had been identified and defined in	

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		PBSPs and those identified and described in monthly notes), as well as their timely completion remained of concern. In addition, IOA data (i.e., reliability estimates) was only reported in approximately 50% of the notes reviewed. And, although the estimated percentage of agreement was typically provided when IOA was discussed, additional specification (e.g., regarding the number of IOA probes, shift, staff involved, behaviors targeted, etc.) would be useful to the Facility over time. Determining whether or not modifications of PBSPs reflected data based decision-making, based on content found within the PBSP, continued to be challenging. Currently, sampled PBSPs were reviewed to determine if statements within plans reflected programmatic changes due to the Facility's collection and review of behavioral data. All (100%) of the sampled PBSPs had specific sections describing the purpose/rationale of the plans as well as other sections that reviewed previous and current interventions, and, at times, their efficacy. In addition, all (100%) of the current PBSPs had a section that described revisions within the current plan. However, despite all of this information, it was still challenging to find conspicuous statements that plans were revised (or not) based on review of behavior data. Of the plans reviewed, conspicuous evidence of data based decision-making was only found in two (25%) of the individuals sampled (i.e., Individual #19 and Individual #318). Lastly, although seven (88%) of the PBSPs stated (or referenced) objective criteria for revision or discontinuation, no (0%) plans identified objective revision criteria with regard to replacement behavior(s). That is, emphasis continued to be placed primarily on the reduction of target behaviors and not on the acquisition of functionally equivalent replacement behaviors. Monthly PBSP notes also were reviewed for sampled individuals, and it was found that three (38%) included descriptions or recommendations related to revising the plan and four (50%) included a determination that the plan would continue to be implemented as written. The remaining exception was Individual #16. Consequently, it appeared that, in most of the notes sampled, clinicians were examining ongoing performance, and, at times, describing revisions in programming. It should be noted, however, that only five (63%) of the monthly notes included behavioral objectives that appeared current. That is, three (38%) of the monthly notes contained behavioral objectives with outdated dates. These included the August monthly note for Individual #318 and Individual #118, as well as the July monthly note for Individual #61. To examine whether or not behavioral data was used to facilitate treatment decisions across other disciplines, a sample of monthly psychiatric reviews was examined. More specifically, monthly psychiatric reviews for May 2013, June 2013, and July 2013 were examined for a sample selected by the Facility and provided as part of the pre-visit document request. Based on this review, it appeared that behavioral data was typically included in the monthly reviews as evidenced by their inclusion within the review	

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		meeting minutes. More specifically, of the 14 individuals reviewed, behavior data was included within all three of the months examined for 13 (93%) individuals. The exception was Individual #183 (i.e., data was not available for the July monthly review). According to documentation provided ("CCSSLC: Individuals with Crisis Intervention Plans," dated 8/18/13), seven individuals currently had Crisis Intervention Plans. In an attempt to examine the quality of current data collection with regard to individuals with both PBSPs and CIPs, three individuals who had an ISP meeting since the Monitoring Team's last visit were selected and provided documentation was reviewed. Based on summary data, this sample reflected 43% of the total number (N=7) of individuals with CIPs and 100% of the CIPs completed since February 2013. This review included the examination of the current PBSP, CIP, and recent PBSP monthly note (i.e., August 2013). Overall, based on provided documentation, the CIP and PBSP had been updated within the past year for three (100%) and two (67%) of the individuals sampled, respectively. The exception was the PBSP for Individual #253 that appeared to be revised over 12 months ago. Examination of the monthly notes revealed that behavior objectives for target and replacement behaviors were only identified for two (67%) of the individuals sampled. That is, adequate objectives were not found for the target behaviors of Individual #40 and for replacement behaviors of Individual #238. In addition, objectives for target and replacement behaviors were only consistent between the PBSP and monthly notes for one (33%) and two (67%) of the individuals sampled, respectively. More specifically, objectives for target behaviors were not consistent across documents for Individual #40 and Individual #238. Similarly, the objective for the replacement behavior was not consistent across documents for Individual #238. It should be noted that the objectives listed on the monthly note for Individual #40 also were outdated. Lastly, and perhaps most importantly, restraint data was only found in two (67%) of the monthly notes sampled. These included the notes for Individual #40 and Individual #253. Despite having a CIP, there was no restraint data found within the monthly note for Individual #238. In an effort to more closely examine the actual data collection system in place across the Facility, a sample of completed behavior data sheets for 12 individuals was reviewed. Based on current summary documentation (i.e., "CCSSLC: Individuals with PBSP," dated 8/23/13), it appeared that there were approximately 117 individuals with PBSPs. Consequently, the current sample reflected approximately 10% of the total number of individuals with PBSPs and behavior data collection systems currently in place. It should be noted that the sample consisted of documentation from individual cases the Facility selected for inclusion in the pre-visit document request. Based on the sample of individuals reviewed, it appeared that a variety of data systems, including monthly, weekly, and hourly data sheets, utilizing primarily partial interval data collection across shifts (or hours) were in place. These systems often collected data on both target and	

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		replacement behaviors. When examining the adequacy of these systems, however, several concerns were noted. For example, although operational definitions were included and adequate for target behavior(s) of 10 of the 12 (83%) individuals sampled, when a replacement behavior was tracked on the same data sheet, it was only adequately defined for four (57%) of the seven data sheets where replacement behaviors were identified. Indeed, in many documents, the replacement behavior was more likely to be referenced or included in an objective, rather than independently defined. Based on the sampled documentation, it appeared that weekly and monthly data sheets were designed to record data collected across shifts (6-2, 2-10, and 10-6), and, in most cases, prescribed partial interval recording (i.e., staff instructed to record a "1" or "0" if the target behavior occurred or did not, respectively). In these cases, a target behavior(s) would be prescribed a unique number and informants were instructed to record the number during the shift in which the behavior was observed. If no targets or replacement behaviors were observed, the interval would be scored a "0." This system appeared to be in place for shift- and hourly-based intervals. It should be noted that frequency count was prescribed for two of the individuals reviewed (i.e., Individual #269 and Individual #367). However, the data that was recorded appeared to suggest that direct support professionals collected partial interval data in one of these cases (i.e., Individual 269). Overall, it appeared that direct support professionals might have confused partial interval with frequency recording as both forms appeared to be utilized at times. In addition to the data sheets described above, all of the individuals sampled had an additional or supplemental system in place to collect data on replacement behaviors. This system was integrated within skill acquisition strategies used to teach replacement behaviors. For six individuals, this system was an additional method used to collect data on replacement behaviors (i.e., for Individual #9, Individual #290, Individual #269, Individual #367, Individual #16, and Individual #305). The remaining six individuals used both systems to collect data on replacement behaviors (i.e., Individual #326, Individual #61, Individual #97, Individual #353, Individual #13, and Individual #46). It should be noted that, although the additional data system was in place, the skill acquisition strategies used to teach replacement behaviors for Individual #97 was less rigorous than the other samples reviewed. Although this additional or supplemental system offers theoretical appeal, several concerns were noted. Review of documentation revealed that replacement behaviors were only adequately defined in the data sheets of eight (67%) of the individuals reviewed. The exceptions included Individual #269, Individual #367, Individual #353, and Individual #16. And, because this was the only system in place to track progress of skill acquisition of replacement behaviors for five (42%) of the current sample, the amount of data collected on these skills was restricted only to those limited, prescribed sessions in which the skill was taught. Similarly, this	

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		limitation appeared inherent in both data collection systems, because using partial interval data collection across shift-based intervals may only lead to three data points per day. Overall, although the current systems appeared to offer some diversity in data collection systems and appeared very simple for staff to implement, the system did not appear to offer the flexibility and sensitivity required within such a large system. That is, given the nature of some of the responses targeted by some of the PBSPs currently implemented, it would appear necessary to track other dimensions of behavior (e.g., frequency, duration, etc.) to ensure a more accurate reflection of responding. Lastly, it was unclear to the Monitoring Team why, other than the hourly data collection (that appeared associated with enhanced level of supervision), no other intervals were utilized (i.e., other than shift-based intervals). Given the current system, the Monitoring Team questions the accuracy of the data collected, because it appeared to foster the collection of data at the end of the shift and not ongoing throughout the shift. Lastly, the Facility did not have a process in place to ensure the timeliness of data collection (i.e., completing data as prescribed). The Facility continued to be in noncompliance with this provision due to the limitations described in detail above, including the timely completion and content of monthly reviews as well as the inadequacy of the current data collection systems. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that monthly progress notes are consistent with the PBSPs and contain IOA and treatment integrity data. In addition, the Facility should consider utilizing systems that are more flexible and ensure more accurate data collection, as well as systems that provide checks that data is being collected as prescribed.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	Progress continued to be observed in the completion of standardized tests of intelligence and tests of adaptive behavior. In addition, the increasing use of the "Comprehensive Psychological Evaluation" format continued to be evident. As presented with regard to Section K.6 of the Settlement Agreement, of the sampled psychological assessments reviewed, 21 (95%) psychological assessments appeared to be updated within the last 12 months. Of these, 22 (100%) had a review of personal history, medical status, and psychiatric and behavioral status. In addition, 22 (100%) individuals had an ICAP evaluation completed within the last three years. In addition, 22 (100%) contained results of previously completed standardized tests of intelligence, with 20 (91%) of these tests completed within the past five years. Tests of adaptive functioning were reported in 22 (100%) of the current psychological assessments, with 22 (100%) of these tests completed within the past five years. However, when examining the timeliness of these psychological assessments, it appeared that only 13	Noncompliance

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		(59%) were completed prior to the ISP. Nonetheless, despite concerns regarding the timeliness of completion and/or review of psychological assessments, there was continued progress noted with regard to the completion of current intellectual assessments and tests of adaptive functioning. 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. As found in the current sample, 15 had a Reiss Screen completed within the last 12 months. The remaining individuals were noted to currently be receiving psychotropic medication and, consequently, ongoing psychiatric oversight. Although not a requirement for substantial compliance (i.e., the Facility could have chosen to develop and implement a system to identify relevant changes in status for which application of the Reiss would be appropriate), 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 more specifically discussed above with regard to Section J.7 of the Settlement Agreement. As described in the Monitoring Team's previous reports, a comprehensive psychological evaluation format had been developed and implemented for individuals who had PBSPs. More specifically, the comprehensive psychological assessment was developed in an effort to integrate the previously formatted psychological evaluation with the structural and functional behavior assessment. As noted in the Monitoring Team's previous report, the majority of sampled assessments appeared very comprehensive and detailed and included information required within psychological evaluations as well as functional behavior assessments. At that time, these evaluations appeared likely to offer utility to the IDT when planning treatment and interventions. As presented with regard to Section K.6 of the Settlement Agreement, of the sampled psychological assessments reviewed, 16 of the sampled psychological assessments were completed using the comprehensive psychological assessment format and six were completed using the psychological evaluation format. It was unclear why the newer comprehensive format was not utilized for three of the individuals sampled, because these individuals had PBSPs (i.e., Individual #198, Individual #305, and Individual #290). It appeared that the psychological evaluation/update for Individual #305 and Individual #290 utilized an older format (template dated 6/1/11), and a separate psychological assessment as well as structural and functional behavior assessment were completed for Individual #198 using previously observed formats. Nonetheless, in an attempt to more closely examine the quality of current comprehensive psychological evaluations, and	

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		assess recent progress toward compliance within this provision of the Settlement Agreement, a sample of eight individuals who had an ISP meeting since the Monitoring Team's last visit and who also had a comprehensive psychological assessment completed during this time period were selected and reviewed. Based on provided summary data (dated 8/18/13), this sample reflected approximately 13% of the total number of comprehensive psychological assessments (N=64) currently in place and 38% of those completed within the last six months (N=21). Review of the eight sampled comprehensive psychological assessments indicated that eight (100%) utilized a standardized process, including interviews, rating scales, and/or direct observation, widely accepted within behavior analysis. Of these eight assessments, eight (100%) utilized both indirect and direct measures, contained content that investigated whether or not the behaviors were learned or biological, identified potential antecedents and consequences, and described/summarized potential functions relevant to problematic behavior. In addition, seven (88%) identified potential setting events/motivating operations (the exception was Individual #371). Consistent with previous findings, it appeared that some authors of the assessments could have more clearly discriminated between establishing operations and more immediate potential antecedents (e.g., Individual #318 and Individual #234). Lastly, of the eight assessments, all (100%) identified functionally equivalent replacement behaviors, however, the operational definitions could have been stronger for Individual #318. Overall, summary data (dated 8/18/13) indicated that approximately 64 comprehensive psychological evaluations were currently in place. Given the total number of PBSPs that are in place (N=117), it appeared that approximately 53 individuals would still require the development of the new comprehensive psychological evaluation format. As reported in Monitoring Team's previous reports, concerns remained with regard to the length of these reports, including a considerable amount of redundancy. That is, the reports continued to describe specific behavior interventions, detail several behavioral objectives, and include data that could be found in other documentation. The Monitoring Team had previously suggested that raw data, currently described in the assessments, be concisely summarized in the assessment and be stored for further examination, if necessary. Lastly, the rationales provided for these assessments continued to reflect revision based on the ISP rather than revision due to the lack of progress. The Facility should remain vigilant in updating these assessments when the current and/or ongoing functioning of the individual warrants review and/or revision. In summary, current evidence continued to reflect ongoing progress in the completion of comprehensive psychological assessments. However, despite this progress, a substantial number of individuals with PBSPs did not yet have comprehensive psychological	

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		assessments completed. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to ensure the development of comprehensive psychological evaluations for all individuals with PBSPs. In addition, the Facility should consider revising the evaluation to enhance its efficient completion as well as its accessibility and utility.	
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 and complete psychological assessment 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 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. It should be noted that the term psychological assessment used here refers to documents provided for review to the Monitoring Team that included those entitled "Comprehensive Psychological Assessment," "Psychological Assessment," or "Psychological Evaluation/Update." To determine whether or not psychological assessments were based on current, accurate, and complete clinical and behavioral data, psychological assessments and ICAP documentation, as provided, from a sample of 22 individuals was examined. This sample included individuals who had had an ISP meeting since the Monitoring Team's last visit. Fourteen of those sampled were randomly selected from across residential programs on campus as part of an onsite document request. That is, in an effort to ensure a representative sample from across residential programs, one or more individuals who met this criterion were selected from each residential program (with the exception of the Sea Horse residence). More specifically, these 14 individuals were from 10 of the 11 residential programs. The remaining eight were randomly selected from documentation the Facility submitted as part of the pre-visit document request. Overall, the entire sample represented individuals from every residence on campus. Given the current census of 241 individuals at the time of the current visit, this sample reflected approximately 9% of the total number of psychological assessments. Alternatively, since provided summary documentation indicated that approximately 85 psychological evaluations had been completed since the Monitoring Team's last visit, it was estimated that the current sample reflected approximately 26% of the psychological assessments completed since the Monitoring Team's last visit.	Noncompliance

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		Of the sampled assessments reviewed, 21 (95%) psychological assessments appeared to be updated within the last 12 months. The exception was the psychological assessment for Individual #238 that was not dated. Of the psychological assessments reviewed, 22 (100%) of the sampled individuals had an ICAP evaluation completed within the last three years. It was noted, however, that the most recently completed ICAP evaluation was not integrated into the current psychological assessments of two individuals reviewed (i.e., Individual #137 and Individual #138). Of the psychological assessments reviewed, 22 (100%) contained results of previously completed standardized tests of intelligence. These assessments generally included the use of the Wechsler, Slosson, Toni, and/or Peabody tests. Overall, 20 (91%) of these intelligence tests were completed within the past five years. The exceptions included the assessments for Individual #98 (i.e., the Wechsler was completed in March 2004) and Individual #118 (i.e., the Wechsler was completed in August 2002). Continued progress in this area, as noted in the Monitoring Team's previous report, was evident within the current sample as well. Tests of adaptive functioning (e.g., Vineland Adaptive Behavior Scales) were reported in 22 (100%) of the current psychological assessments. Overall, 22 (100%) of these tests of adaptive behavior were completed within the past five years. The current results continued to evidence improvement in this area since the Monitoring Team's last review. Current review of sampled documentation continued to reflect variability in the template used for psychological assessments. As presented in the Monitoring Team's previous reports, the comprehensive psychological assessment (CPA) was the integration of the previous psychological assessment with the structural and functional behavior assessment (SFBA). Based on verbal reports from the former Director of Behavioral Health Services, it was expected that a CPA would be completed for any individual with a PBSP (i.e., those who required a SFBA). Currently, of the 19 individuals with PBSPs in the current sample, 16 (84%) were developed using the CPA format. The exceptions included Individual #290, Individual #305, and Individual #198. It appeared that the psychological evaluation/update for Individual #305 and Individual #290 utilized an older format (template dated 6/1/11). However, content within the document appeared to include elements reflective of functional behavioral assessment, and, consequently, similar to those found within the current comprehensive psychological assessment. In addition, it appeared that the psychological assessment and structural and functional behavior assessment was completed for Individual #198 using previously observed formats. As noted with regard to Section K.5, it was unclear to the Monitoring Team why some individuals with PBSPs did not have their assessment completed utilizing the newer comprehensive psychological evaluation format.	

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		Because 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, limited progress was noted in the provision of psychological assessments for all CCSSLC residents, including those for individuals newly admitted to CCSSLC. To determine whether or not psychological assessments were completed, updated or reviewed as often as needed, psychological assessments from a sample of 22 individuals was examined. This was the same sample as described in Section K.6. Of the sampled psychological assessments reviewed, 21 (95%) psychological assessments appeared to be updated within the last 12 months. However, when examining the timeliness of these psychological assessments, it appeared that only 13 (59%) were completed prior to the ISP. This finding was based on the comparison of the ISP date with the recorded date found on the first page of the assessment. However, when using the signature date on the plan as the comparison, it appeared that only five (23%) assessments were completed prior to the ISP In an effort to estimate whether or not individuals had a current psychological assessment, the date of psychological evaluations, as listed on the Behavioral Services database (dated 10/1/13) was reviewed. According to the recorded "psychological evaluation date," as of the Monitoring Team onsite visit, 160 (66%) individuals appeared to have a psychological evaluation that was completed/updated within the past 12 months. 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 the dates listed, it appeared that approximately 82 (34%) of the assessments, based on the census of 241, were outdated. This finding was consistent with the finding reported in the Monitoring Team's last report. In addition, the fidelity of the Behavioral Health Services database was examined through the comparison of "psychological evaluation" dates as listed within provided summary documentation ("Psychological evaluations" dated 10/1/13) compared to the actual dates recorded on the sampled psychological assessments. Of the 21 records reviewed, only eight (38%) of the current sample had the same dates. Consequently, the Monitoring Team continued to question the accuracy of the summary listing. According to the Facility Self-Assessment (dated 9/13/13), seven individuals were admitted between 2/1/13 and 7/31/13. This included Individual #17, Individual #35, Individual #39, Individual #98, Individual #27, Individual #115, and Individual #33. It should be noted that two of these individuals (i.e., Individual #115 and Individual #39) were identified as new admissions and reviewed in the Monitoring Team's previous report, but at that time, documentation for these individuals was not available for review.	Noncompliance

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		Subsequently, consistent with the Facility's Self-Assessment, these seven individuals were included in the current review. Of the seven new admissions, only six psychological assessments were available for review by the Monitoring Team. More specifically, the Facility indicated that there was "no psychological evaluation" for Individual #33. Of the six available psychological assessments, six (100%) included a review of personal history, medical status, and psychiatric and behavioral status. In addition, six (100%) evidenced competed Reiss evaluations within the past 12 months. In addition, six (100%) individuals had an ICAP evaluation completed within the last three years. In addition, six (100%) contained results of previously completed standardized tests of intelligence. However, only two (33%) of these tests were completed within the past five years, and, of these, only one reported actual scores. That is, although the Slosson was recently conducted for Individual #17, no scores were obtained. Tests of adaptive functioning were reported in five (83%) of the current psychological assessments. However, only four (80%) of these tests were completed within the past five years. Lastly, when examining the timeliness of the available psychological assessments, it appeared that five (83%) were completed within 30 days of admittance (i.e., when using the recorded "assessment date," "revised date," or "date of evaluation," as found on page one of the psychological assessment). The exception was the assessment for Individual #39 that appeared to be completed more than five months after admission. However, when examining the BSC approval date of each psychological assessment, it appeared that only three (50%) were completed within 30 days of admission. The exceptions included Individual #35, Individual #39, and Individual #27, where the date either exceeded 30 days from admission or could not be identified on any documentation (including both the assessment and the Behavior Health Sciences psychological evaluation database, dated 10/1/13). Once again, determining the completion date of these assessments was challenging, because the date recorded on the actual psychological assessments did not match those recorded in the summary database (i.e., inconsistencies in recorded dates for Individual #27 and Individual #115). As a result of concerns regarding the adequacy and timeliness (including review and approval) of psychological assessments for individuals newly admitted to CCSSLC, as well as the continued questions regarding the accuracy of data in the Behavioral Health Services database, the Facility remained out of compliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure adequate and timely completion (including review) of psychological assessment for all individuals admitted to the Facility and those residing at the Facility, as well as ensure the ongoing accuracy of their Behavioral Health Services database.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing	No progress was noted with regard to the provision of services to individuals requiring psychological services other than PBSPs, including the provision of counseling services.	Noncompliance

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	psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	As noted in the Monitoring Team's previous reviews, counseling supports provided to individuals served by the Facility appeared inadequate. Currently, based on documentation provided, the provision of counseling services did not appear to improve since the Monitoring Team's last review. Indeed, counseling supports changed dramatically in June 2013, as the previously contracted community-based supports were discontinued due to "budgetary reductions" (as indicated in counseling monthly reviews). Consequently, individuals now received counseling supports through Facility psychologists. According to verbal reports from the former Director of Behavioral Services, five of the current psychologists were in the process of "picking up" the counseling needs of the individuals, including developing counseling treatment plans. At the time of the current visit, formal counseling plans were not yet available for review. It should be noted that documentation was provided as evidence of the provision of counseling supports between February and June 2013. This evidence included monthly notes (for two or more months) for 10 (50%) of the 20 individuals identified as receiving counseling supports. In addition, a document detailing each individual's counseling goal(s), counseling objective(s), rationale, and counseling treatment interventions was provided for eight (40%) of the individuals receiving counseling. It should be noted that these did not appear to be formal counseling treatment plans, and, as a result, appeared inadequate. In addition, although many of the counseling objectives appeared measurable, it was unclear if any data was actually collected and reviewed as part of an active quantitative progress monitoring. That is, monthly PBSP progress notes the Monitoring Team sampled and reviewed targeted months following the qualitative change in counseling supports. Indeed, reviews of monthly PBSP progress notes for August for several sampled individuals did not provide any evidence that data was collected on counseling-related behavior objectives (i.e., Individual #253, Individual #118, and Individual #98). Overall, the Facility appeared to be in transition with regard to providing counseling services to individuals the Facility served. The Monitoring Team continues to expect that the Facility will develop comprehensive and rigorous counseling treatment plans. 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. The Monitoring Team's previous report indicated that the ABLLS-R was purchased. Currently, provided documentation evidenced training for Behavioral Health Services Providers and their assistants on the ABLLS-R. However, no documentation was provided as evidence that	

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		the assessment had been utilized. And, although previous reports as well as more recent descriptions of interventions on monthly counseling reviews indicated that Dialectical Behavior Therapy (DBT) would be utilized, the Facility's Self-Assessment reported that, due to the lack of a qualified clinician, DBT had not been provided. Due to the continued inadequacy of the provision of counseling supports, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to improve the quality of counseling treatment plans, including programs designed for implementation by counselors and direct support professionals, as well as ensure adequate and consistent data collection and monitoring/review of these services.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Continued progress was noted in the area of PBSPs. However, concerns regarding the adequacy of staff instructions as well as the receipt of consent and timeliness of implementation were noted. Current summary documentation (i.e., "CCSSLC: Individuals with PBSP," dated 8/23/13) indicated that there were approximately 117 individuals with PBSPs. It was reported (i.e., TX-CC-1309-PH3) that 30 PBSPs were updated since the Monitoring Team's last visit. In an effort to review the adequacy of these PBSPs and assess progress toward compliance with this provision of the Settlement Agreement, a sample of eight PBSPs was selected and reviewed. These included individuals who had an ISP meeting since the Monitoring Team's last visit. In addition, the sample contained four individuals who were randomly selected at the time of the onsite visit from the list of the most recently completed plans as well as four individuals who the Facility selected for inclusion in the pre-visit document request. This sample reflected approximately 7% of the total number of PBSPs (N=117) currently in place and 27% of those completed since the last Monitoring visit (N=30). Of the eight PBSPs reviewed, it was found that: ▪ Eight (100%) included a rationale or purpose for development or revision. However, only one (i.e., Individual #19) of the rationales conspicuously described whether or not the plan was being revised (or not) due to effectiveness; ▪ Eight (100%) included adequate operational definitions of target behavior; ▪ Five (63%) included adequate operational definitions of replacement behavior. The exceptions were Individual #353, Individual #16, and Individual #9; ▪ Eight (100%) included data (in graphic form) of target behavior. However, one individual's PBSP included data on target behaviors that were not identified or defined (i.e., Individual #61); ▪ Six (75%) included data (in graphic form) of replacement behavior. The exceptions were Individual #353 and Individual #16;	Noncompliance

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		▪ Eight (100%) included a description of previous intervention strategies and outcomes; ▪ Seven (88%) included a behavioral objective for the target behavior. The exception was Individual #234. However, multiple objectives for targets that were not identified or defined were included in the PBSP for Individual #61; ▪ Six (75%) included a behavioral objective for the replacement behavior. The exceptions were Individual #234 and Individual #118. However, the behavioral objective for Individual #9 was somewhat unclear; ▪ Eight (100%) appeared to identify potential establishing operations/setting events, antecedents and/or consequences. However, the descriptions of establishing operations/setting events as well as antecedents for some plans appeared vague and often overlapped (i.e., Individual #234 and Individual #353); ▪ Eight (100%) appeared to provide an adequate description of potential function(s) of target behavior; ▪ Seven (88%) included antecedent-based or preventative strategies; ▪ Eight (100%) included teaching strategies targeting the replacement behavior; ▪ Eight (100%) included consequence-based or "intervention" strategies; ▪ Eight (100%) included strategies to use positive reinforcement; ▪ Eight (100%) included data collection strategies. However, only seven (88%) specifically described regular review processes (the exception was Individual #61); ▪ Eight (100%) included strategies to reduce the intrusiveness of strategies and/or criteria for discontinuation of the PBSP; ▪ Seven (88%) included a signature and date. The exception was Individual #16. However, concerns were noted regarding the timely completion of PBSPs as many appeared to be signed and dated months after they were revised (i.e., Individual #19, Individual #234, Individual #318, and Individual #118); ▪ Eight (100%) included the formatting for conducting integrity checks, but none (0%) included the instructions/scoring section; and ▪ Eight (100%) included a two- to four-page staff instructions section. However, in addition to the omission of the integrity check instructions/scoring section (as noted above), five (63%) of the staff instructions had one or more sections that appeared inadequate or were missing. For example, staff instructions did not appear to contain prevention strategies for Individual #61, and sections on replacement behavior and function were not adequate for Individual #353. In addition, the replacement behavior section for Individual #19, the antecedent- and consequence-based sections for Individual #318, and the target behavior, replacement behavior and function sections for Individual #16 appeared inadequate.	

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		Overall, the PBSPs continued to reflect improvement in the inclusion of necessary elements. However, these plans continued to include information that was found in other documents (e.g., comprehensive psychological assessment, monthly progress notes) and their inclusion appeared redundant and unnecessary. In addition, the same information was often included in both the main body of the PBSP as well as the staff instructions. And, as noted above, many staff instruction sections did not include all of the elements necessary to implement the plan with a high level of integrity. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility place emphasis on ensuring that the staff instructions, arguably the most important section, contain all of the elements necessary for staff to implement the plan with integrity. This includes definitions of target and replacement behavior(s), identification of function of behavior(s), antecedent- and consequence-based strategies, teaching strategies for training of replacement behaviors, and description of data collection procedures. Lastly, these abbreviated instructions should be clear, precise, and concise. 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 or Facility Director consent) were examined during the onsite visit. This sample of consents included five individuals, and represented approximately four percent of the total number of PBSPs currently implemented (N=117). Onsite documentation review revealed that only two (40%) of the individuals sampled had all of the necessary and current consents in their records. Exceptions included Individual #318, Individual #118, and Individual #138, who's records were missing one or more consents. This finding was relatively consistent with summary documentation (CCSSLC: Individuals with PBSPs, dated 10/4/13) provided by the Facility that indicated that approximately 32% of PBSPs were delinquent. More specifically, based on the dates listed on the summary documentation, it appeared that the Facility judged a plan to be "delinquent" if it had been more than 12 months since receipt of consent or BSC approval. However, using a more conservative approach [i.e., using only the date of guardian or Director consent (including the lack of any evidence of consent)], the Monitoring Team estimated that approximately 49% of plans were delinquent (i.e., based on the date of the onsite visit, it had been in excess of 12 months since receipt of guardian/Director consent or the plan appeared to be implemented without evidence of any consent). Further examination of documentation (i.e., TX-CC-1309-VIII.29) indicated that approximately 36 (31%) individuals appeared to have their PBSPs implemented prior to receipt of consent. More specifically, 36 individuals in the summary listing appeared to receive consent (as reflected by the recorded "consent date") after the PBSP was	

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		implemented (as reflected by the "implementation date"), or the PBSP appeared to be implemented without any evidence of receipt of consent (as reflected as the absence of a consent date). In addition, review of the same documentation indicated that approximately 22 (19%) PBSPs were implemented 14 days or more following receipt of consent. Although not related to the compliance finding for this subsection of the Settlement Agreement, the following information is provided as a courtesy to the Facility, because of the serious nature of a failure to obtain consent for the implementation of restrictive practices, such as restraint. Further examination of provided documentation (i.e., TX-CC-1309-PH3) indicated that approximately two (29%) individuals appeared to have their Crisis Intervention Plans implemented prior to receipt of consent. This included Individual #61 and Individual #172. In addition, review of the same documentation indicated that approximately two (29%) were implemented 14 days or more following receipt of consent. This included Individual #40 and Individual #253. The Facility remained in noncompliance because the quality of behavioral programming was not sufficient for the newest plans and improvements 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. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to improve the quality of PBSPs as well as the abbreviated staff instructions. In addition, the Facility should ensure that all PBSPs receive the necessary consent and approval prior to implementation.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Progress continued to be noted in area of data display. Concerns were noted, however, with the continued inadequacy of IOA data collection. As previously discussed with regard to Section K.4 of the Settlement Agreement, progress continued to be evident in the quality of the monthly progress monitoring. However, concerns with regard to the adequacy of monthly PBSP progress notes were noted. These included inconsistencies between the PSBP and monthly notes, inadequate reporting of IOA and treatment integrity, and their timely completion and review. In an attempt to more closely examine the quality of current data collection, display and monitoring and, consequently, assess progress toward compliance with this provision of the Settlement Agreement, a sample of 12 individuals who had an ISP meeting since the Monitoring Team's last visit and who also had a PBSP were selected and reviewed. This examination included the review of the provided current PBSP as well as monthly notes from August 2013 for each individual sampled. Because graphic displays were found in both PBSPs and monthly PBSP progress notes, each is reviewed here. Review of PBSPs indicated that, of the 12 individuals sampled:	Noncompliance

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		▪ Nine (75%) included graphed data across months. Exceptions included Individual #98 (new admission), Individual #253, and Individual #368; ▪ Nine (75%) included one or more graphs displaying target behavior(s); ▪ Five (42%) included one or more graphs displaying replacement behavior(s). These included Individual #238, Individual #19, Individual #371, Individual #198, and Individual #234; ▪ Of those with graphs, nine (100%) had X axis labels (months). However, the X-axis on the replacement behavior graph for Individual #371 was illegible; ▪ Of those with graphs, nine (100%) had Y-axis labels. However, as discussed below, concern was noted regarding the use of "frequency" as the label; ▪ Nine (100%) utilized condition change lines and condition labels; ▪ Nine (100%) utilized one or more data path(s) and data markers, when necessary; and, ▪ Nine (100%) utilized trend lines. Review of the August 2013 monthly PBSP progress notes indicated that, of the 12 individuals sampled: ▪ Twelve (100%) included graphed data across months; ▪ Twelve (100%) included one or more graphs displaying target behavior(s); ▪ Twelve (100%) included one or more graphs displaying replacement behavior(s); ▪ Eight had one or more graphs utilized to display data on "monitored" behavior, restraint (frequency and duration), desensitization, and/or refusals to attend programming, in addition to graphic display of target and replacement behaviors; ▪ Twelve (100%) had X axis labels (months); ▪ Twelve (100%) had Y-axis labels. However, as discussed below, concern was noted regarding the use of "frequency" as the label; ▪ Twelve (100%) utilized condition change lines and condition labels; ▪ Twelve (100%) utilized data paths and data markers, when necessary; and ▪ Twelve (100%) utilized trend lines. Overall, the current review noted improvement in the use of adequate graphic displays. One example of where this was noted was the graph used to illustrate the use of restraints for Individual #253. That is, the graph utilized multiple Y-axes and data paths to effectively display data on frequency and duration of restraint. Although continued improvement in the quality of graphic displays was observed in the current sample, a few concerns were noted. As previously described, inconsistency between the PBSP and monthly progress notes with regard to the behaviors identified and targeted for display was observed. This inconsistency could lead to difficulty, for	

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		example, in effectively assessing the progress of behavioral programming on identified target or replacement behavior (e.g., Individual #234). Consequently, the Facility is encouraged to examine the consistency across these documents in an effort to ensure graphic display and effective monitoring of behaviors addressed by current behavioral (or other) programming. The Facility should consider determining where graphic display is most useful and selectively integrate the data, thereby reducing the redundancy of information and the potential for error across documentation. As noted above, the use of condition change lines appeared more common in the current review. Based on the documents reviewed, it appeared that condition lines were used to primarily illustrate baseline and treatment phases. Although the increasing use of these lines was viewed as an improvement, the delineation of these phases appeared somewhat arbitrary. Nonetheless, it was noted that condition change lines (and labels) were increasingly utilized to illustrate other changes (e.g., medication changes) as well. One of the more serious concerns noted was the use of the term "frequency" as the Y-axis label on all of the graphs reviewed. Although the Monitoring Team did not confirm this, it was believed, based on the completed behavior data sheets reviewed and previously discussed with regard to Section K.4 of the Settlement Agreement, that some (if not most) of the data collected was partial interval data. If this is true, using the term "frequency" is inaccurate. In order to move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that staff understand the differences between frequency and partial-interval data collection and ensure accuracy in the display of all data. As reported in the Monitoring Team's previous reports as well as within the current Section K.10 Action Plan, the Facility set an expectation that inter-observer agreement probes would be completed monthly for each individual with a PBSP. In addition, it was expected that IOA data would be reported in all monthly PBSP progress notes. Given these expectations, previous reports have noted inconsistent and inadequate completion of IOA probes each month. That is, as reported in the Monitoring Team's last report, although IOA probes were discussed within the monthly notes of nine (90%) of the individuals sampled, actual IOA data was only available for six (60%) of the individuals reviewed. Currently, as previously described with regard to Section K.4 of the Settlement Agreement, IOA data was only reported in approximately four (50%) of the notes reviewed. As reported in the Monitoring Team's last report, it appeared that two, two, three, zero, 10, nine, 50, and 90 IOA probes were completed in June 2012, July 2012, August 2012, September 2012, October 2012, November 2012, December 2012, and January 2013, respectively. Over the course of this eight-month period, approximately 167 IOA sessions were completed by psychologists and/or psychology assistants and produced	

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		estimated agreement coefficients from 80 to 100%. Currently, based on provided summary documentation (i.e., TX-CC1309-PH4), it appeared that 84, 78, 84, 96, 42, 95, 39, and 73 IOA probes were completed in February 2013, March 2013, April 2013, May 2013, June 2013, July 2013, August 2013, and September 2013, respectively. As a comparison, over the course of this eight-month period, approximately 591 IOA sessions were completed by psychologists and/or psychology assistants and produced estimated agreement coefficients from 40 to 100%. To provide more perspective, it appeared that from June 2012 through December 2012, an average of approximately 11 IOA probes per month were conducted. More recently, from January 2013 through September 2013, an average of approximately 76 IOA probes per month were conducted. After controlling for individuals who had multiple IOA probes completed each month and using an estimate of 117 total PBSPs implemented each month, the Monitoring Team estimated that, on average, 9% (range of 0-43%) and 59% (range of 30-77%) of the required IOA probes were completed each month in 2012 and 2013, respectively. Consequently, although improvement was observed in the increasing completion of IOA probes since the Monitoring Team's last visit, these still appeared to be inadequate given the stated expectation of the Facility. It should be noted that the Monitoring Team was unable to efficiently determine other relevant data, including which residences, programs, and/or shifts, related to the completed IOA probes. In addition, the Facility should utilize direct support professionals to collect IOA data, as these are the staff members who collect the majority of the data, and, as a result, these are the staff that should have the greatest degree of agreement. 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. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure adequate IOA for all individuals with PBSPs and continue to improve elements found within the notes, including the identification of IOA estimates.	
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.	Progress was noted in the Facility's attempt to ensure that PBSPs were written so they could be understood and implemented by direct support professionals. However, provided data indicated that, although improvement was noted, readability rates were still unacceptable. As described in the Monitoring Team's previous reports, the Facility utilized a brief "staff instructions" format and monitored its readability level to ensure that PBSPs, specifically the staff instructions section, could be understood and implemented by direct support professionals. As reported in the previous report, the readability criterion was changed from at or below a 7th grade reading level to at or below an 8th grade level. In an effort to estimate the accessibility of PBSPs by direct support professionals, the readability	Noncompliance

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		estimates of a sample of PBSPs were reviewed. The sample included 12 individuals who were randomly selected from those individuals who had an ISP meeting since the Monitoring Team's last visit. This sample reflected approximately 10% of the total number of PBSPs (N=117) currently in place. Of the 12 PBSPs sampled, nine (75%) of the corresponding staff instructions appeared to be at or below an 8th grade reading level. The exceptions included three PBSP staff instructions of Individual #40, Individual #98, and Individual #253 that were above an 8th grade reading level. Documentation provided by the Facility (CCSSLC Readability Spreadsheet All Clients as well as TX-CC1309-PH4) suggested that readability estimates had been generated on approximately 71 PBSPs. Based on the provided summary data, it appeared that approximately 51 (72%) were at or below an 8th grade level. Given that the former Director of Behavioral Services had indicated that any PBSP with a readability estimate above an 8th grade level would be revised prior to receiving BSC approval, it was surprising to the Monitoring Team that 11 (51%) of these that exceeded the criterion were completed since the Monitoring Team's last visit. As previously presented with regard to Section K.9, eight PBSPs, including the abbreviated staff instructions sections, were selected and reviewed. This sample reflected approximately 7% of the total number of PBSPs currently in place and 27% of those completed since the Monitoring Team's last visit. As previously noted, all (100%) of the PBSPs included a two- to four-page staff instructions section. Based on examination of these abbreviated instructions, it appeared that only three (38%) were adequate. These included Individual 234, Individual #118, and Individual #9. However, five had one or more sections that appeared inadequate or were missing. For example, staff instructions did not appear to contain prevention strategies for Individual #61, and sections on replacement behavior and function were not adequate for Individual #353. In addition, the replacement behavior section for Individual #19, the antecedent- and consequence-based sections for Individual #318, and the target behavior, replacement behavior and function sections for Individual #16 appeared inadequate. It should be noted that none of the teaching strategies were structured using the SAP format. Indeed, most of the individuals sampled had supplemental data sheets that also contained teaching strategies. The Facility should consider eliminating the redundancy by removing the teaching strategies from the staff instructions and more fully approximate the SAP format using the supplemental data sheet. As a result of these deficiencies, the Monitoring Team found these confusing, and not easy for direct support professionals to understand how to implement. Although some progress was noted above, the Facility remained in noncompliance with this provision due to the continued inadequacy of the most recent BSP format, including the staff instructions making them difficult to understand. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure	

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		adequate readability levels and improve the staff instructions.	
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.	Efforts toward the provision of competency-based training were noted. As noted in the Monitoring Team's previous report, according to data provided at that time (i.e., the Facility Self-Assessment), 941 competency-based training sessions had been completed for 69 individuals with PBSPs between 5/1/12 and 1/31/13. At that time, the Facility also estimated that 57% of those with PBSPs had direct support professionals who were trained to competency. Current estimates, based on data provided in Section K.12 of the Facility Self-Assessment, 347 competency-based training sessions had been completed since the Monitoring Team's last visit. In addition, according to the Facility, of the 117 individuals with PBSPs, 18 (15%) had staff currently trained to competency on their PBSPs. It should be noted that, as consistent with the Monitoring Team's previous review, these numbers could not be confirmed due to the lack of detailed summary data provided by the Facility. That is, given the provided documentation, it was not possible to confirm which staff members were trained on which PBSPs. However, it was evident, based on provided summary documentation (i.e., Individuals with PBSPs, TX-CC-1309-P3, dated 10/1/13), that 16 PBSPs were trained since the Monitoring Team's last visit in April 2013, and that, overall, 22 (19%) PBSP had been trained (so far) in 2013. Lastly, based on this summary data, it appeared that 53 (45%) of PBSPs were trained within the last 12 months (between October 2012 and September 2013). To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility identify those PBSPs that require all staff working with the individual to demonstrate adequate competency (i.e., based on integrity checks). This may assist in ensuring a high degree of integrity for the PBSPs of the individuals at greatest risk. Currently, verbal reports continued to suggest that only Behavioral Health Services Providers or their assistants completed all of the competency-based trainings of PBSPs. As previously presented, it appeared that this direct model might be somewhat inefficient and might need to be supplemented by a more indirect model. That is, where the Behavioral Health Services Specialist (i.e., "expert") provides competency-based training to other trainers (e.g., behavioral health services assistants, home team leaders, etc.) who share the responsibility in training the direct support professionals. The Behavioral Health Services Specialists 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. In addition, it had previously been recommended that the Facility identify the individuals who demonstrate the most at-risk behavior and determine which PBSPs require the most immediate competency-based training and subsequent treatment	Noncompliance

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		integrity checks. As noted above, to move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that all staff working with the most at-risk individuals demonstrate adequate competency on PBSPs. This process could also include determining which plans would have priority when completing IOA probes as well. In addition to these considerations, the Facility should identify a process for demonstrating competency for challenging behaviors that occur very infrequently. As reported in the Monitoring Team's previous reports as well as within Section K.12 of the current CCSSLC Action Plan, there is a requirement that at least one integrity (reliability) check be completed each month for each PBSP. As previously reported, this expectation appeared to be initiated in December 2012. Data reviewed at the time of the Monitoring Team's last visit indicated that 98 integrity checks (with reported integrity estimates ranging from 81 to 100%) had been completed. Currently, based on provided summary documentation (TX-CC1309-PH4) between February and August 2013, it appeared that a total of 318 integrity checks had been completed. More specifically, it appeared that a total (including the range of corresponding integrity estimates) of 75 (81-100), 47 (78-100), 74 (80-100), 62 (100), 12 (100), 23 (100), and 25 (100) integrity checks were completed in February, March, April, May, June, July, and August 2013, respectively. Given this data, it appeared that, on average, 45 integrity checks were completed each month between February and August 2013. Based on the estimated total number of PBSPs in place (N=117), the Monitoring Team estimated that, on average, 39% (with a range of 10-64%) of the required integrity checks were completed each month. Consequently, although improvement was observed in the increasing completion of integrity checks (i.e., with most of the checks evidencing acceptable integrity estimates) since the Monitoring Team's last visit, these still appeared to be an inadequate number completed each month given the stated expectation of the Facility. In addition, the Monitoring Team could not efficiently determine the extent to which integrity checks were completed. That is, summary documentation only provided listings of individuals with PSBPs that had integrity checks completed each month. Consequently, as the Monitoring Team learned, the format of this information was unlikely to facilitate efficient monitoring of this ongoing process. That is, in its current state, it would be difficult to efficiently review the summary data to determine, for example, the number of integrity checks completed across residences, programs, and/or shifts as well as compare current progress with expected completion rates (and reliability estimates) over time. As previously presented with regard to Section K.9 and K.11 of the Settlement Agreement, of the eight sampled PBSPs currently reviewed, all (100%) included an abbreviated two- to four-page staff instructions section. However, based on current examination of these abbreviated instructions, it appeared that only three (38%) were adequate. In addition, it was noted that the sampled staff instructions varied from the	

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		format initially developed. That is, the Facility had originally revised the format of the staff instructions to allow efficient scoring during integrity checks, including the use of scoring instructions at the end of the document. Indeed, previously reviewed samples as well as current samples (provided within section K.12 of the Section K Presentation Book) appeared to use this more detailed rubric. Consequently, it was unclear why none of the sampled staff instructions used this more detailed rubric. The provision of adequate competency-based training, including the completion of integrity checks, across the Facility remained inadequate for the reasons noted above. As a result, the Facility remained in noncompliance with this provision. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure general competency-based training for all direct support professionals on behavior support plans, and a process to ensure that staff working with the most at-risk individuals (as identified in Facility policy) have demonstrated competency on individual-specific plans. This might require the development of a computer-based data management system that would allow efficient monitoring of competency-based trainings (if not already in place), and ensure adequate treatment integrity.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	As previously reported with regard to Section K.2 of the Settlement Agreement, the top two leadership positions within the Behavioral Health Services Department were open. In addition, recent verbal reports also indicated that one Behavioral Health Services Providers as well as four Behavioral Health Services Assistant positions were currently vacant. Consequently, three Behavioral Health Services Assistants were currently in place to support the 12 budgeted psychologist positions. Given the current census of 241 individuals at the time of the Monitoring Team's visit, and the recognition that the Director and Assistant Director of Behavioral Health Services did not carry caseloads, an approximate average ratio of 1:22 Behavioral Health Services Specialists-to-individual served was determined. With three Psychology Assistants currently employed, the Facility did not meet the ratio of one Psychology Assistant for every two Behavioral Health Services Specialists. It should be noted that the Monitoring Team could not confirm these numbers of current staff, because the provided documentation appeared somewhat outdated (TX-CC-1309-VIII.15, dated 8/21/13), and was not consistent with recent verbal reports. The Facility was rated as being in noncompliance with this provision, because, in addition to not having a sufficient ratio of Behavioral Services staff to individuals, 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	Noncompliance

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		observed at the Facility. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue to support Behavioral Health Services Providers in their successful completion of required academic coursework as well as continue to ensure required supervision according to the Behavior Analyst Certification Board eligibility guidelines.	

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 Medical Director, if new since the last visit; o Name and degrees of all primary care providers that were new to the Facility since last Monitoring Team visit; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing Cardiopulmonary Resuscitation (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 Since the last on-site review, 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 during this time period; o Copy of any clinical guidelines developed and implemented since last Monitoring Team visit; o Minutes of Infection Control (IC) 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 each PCP, two most recently completed quarterly medical reviews from each assigned residence; o For any 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's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last visit, with separate reports/data of external medical peer review audits from internal medical peer review audits (both general medical and medical management audits), including information concerning number of corrective action plans, and 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 autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory. Submitted requested information included location at time of death, whether DNR, whether receiving hospice services, ambulatory status, and whether supplemental oxygen prescribed as part of routine care. Date of any ethics committee meeting that

	reviewed the individual's terminal course, if applicable. Submitted information for Individual #139 and Individual #156; o Mortality Reviews (i.e., clinical, administrative, and nursing reports) since Monitoring Team's last visit; o Corrective actions related to Mortality Reviews (including status reports on previous recommendations made prior to last Monitoring Team visit which had follow-up closure or action steps completed); o Notes and orders for any Do Not Resuscitate (DNR) orders and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (i.e., clinical/administrative) that remain incomplete/outstanding; o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination for following individuals: Individual #122, Individual #215, Individual #101, Individual #4, Individual #311, Individual #218, Individual #119, Individual #251, Individual #366, Individual #89, Individual #313, Individual #280, Individual #70, Individual #55, Individual #20, Individual #239, Individual #25, Individual #376, Individual #113, and Individual #333; o Specialty clinic schedule per month for past six months (including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, 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 List of all outside consultations for medical purposes for the past six months, categorized by specialty including the list of appointments made, the list of appointments completed, the list of appointments refused by the individual, 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 pending; o List of individuals: a) With tracheostomies; b) With fractures, date of fracture, including the type of fracture (i.e., compound, simple, stress, etc.), bone fractured (location); c) With injuries requiring visit to ER or hospitalization since the last on site review; and d) With pica or ingesting inedible object, date of ingestion, object/liquid 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 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 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 all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person (i.e., 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 (i.e., 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 (i.e., specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake and Vitamin D 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 those going to the ER and not hospitalized, copy of IPN from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility record orders, IPN/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to the Monitoring Team's visit (in order to allow completion of recommendations): Individual #158 (6/9/13), Individual #122, Individual #301, Individual #205, Individual #145, Individual #326, Individual #310, Individual #363, Individual #158 (5/22/13), and Individual #146; o For those admitted to hospital, copy of IPN from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, IPN/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): Individual #22, Individual #301, Individual #340, Individual #97, Individual #115, Individual #348, Individual #236, Individual #202, Individual #356, and Individual #87; o For these same 10 most recent hospitalizations that have been completed, copy of Hospital Liaison Nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months, if applicable; o Infectious disease data per quarter, by category of infection, last two quarters; o Summary report or trend analysis of infectious disease/communicable disease last two quarters; o Avatar pneumonia tracking forms/pneumonia data from Avatar database for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last

	swallow study; o Absolute numbers of new cases (prior year, by month) for the following: a) pneumonia; b) decubitus ulcers; c) UTIs; and d) bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: a) malignancy; b) cardiovascular disease; c) diabetes mellitus; d) sepsis; e) bowel obstruction or bowel perforation, and f) pneumonia; o List of individuals who have 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 name of individual, residence/home, diagnosis (type of seizure), and medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes): Individual #127, Individual #371, Individual #163, Individual #319, and Individual #269; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last visit, date of prior visit to the neurologist for these same individuals; o List of those with status epilepticus since the last monitoring visit; o List of those going to ER for uncontrolled/prolonged/new onset seizure since last Monitoring Team visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals with diagnosis of seizure disorder on one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (e.g., Phenobarbital, Dilantin, Mysoline, and Felbamate); 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 (on-campus and off-site), list of appointments that were completed and ones not completed (with reasons); o For hospitalizations in prior six months, copies of follow-up ISPAs; o Number of individuals with a diagnosis of seizure disorder on no antiepileptic medications; o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at morning medical meetings for period of 30 to 60 days prior to the Monitoring Team's visit, any documents providing evidence of closure (i.e., minutes of medical staff meeting, copy of ISPA addressing concern, etc.); o For the last five pre-treatment sedations administered for a medical procedure, all

	information related to medical pre-treatment sedation used, including consents, Human Rights Committee (HRC) approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries. Information submitted for following individuals: Individual #348, Individual #228, Individual #153, Individual #141 on 7/25/13, and Individual #141 on 7/29/13; o Ten most recent PNMT recommendations for which physician orders were written based on those recommendations; o ISPAs addressing missed appointments or refusals for the past three months (for mammograms, colonoscopies and off-site and on-site consultation appointments); 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 (including whether attempted but unsuccessful), date of last pap smear with determination of adequate reading, sufficient sample, etc., (including whether attempted but unsuccessful), if pelvic not done, the reason/indication, and if pap smear not done including the reason/indication. For those with a history of hysterectomy, list of the reasons for the hysterectomy; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, how often the data was collected, the staff that completed the audit/monitor survey/review, and whether any inter-reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. For data collected periodically rather than continuously, the frequency of the data collection; 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 ISP and subsequent addendums, most recent Behavior Support Plan (BSP), and past three medical quarterly reviews: Individual #333, Individual #311, Individual #127, Individual #369, Individual #113, Individual #95, Individual #160, Individual #278, Individual #356, and Individual #124; o Minutes of the medical morning meeting with handouts during the Monitoring Team visit (10/1/13, 10/2/13, and 10/3/13); o Medical Department caseload per PCP for 10/1/2013; o Weight management guidelines; o Training documentation and guideline for "New Section G Monitoring Tool;" o Competency checklist of "Performing nasopharyngeal suctioning;" o Description of process in calculating daily calcium and Vitamin D for PCP orders;

	o Medical Morning Meeting Attendance 9/23/13 to 9/27/13; o Documentation of closure (including training rosters) for administrative death review recommendations; o QA follow up per month of CAPS for external and internal medical audits June 2013 and internal medical audit March 2013; o For the last year, a list of all individuals who have been seen in the Emergency Room, including the date seen at the ER, and reason for visit; o For the last year, a list of all individuals who have been admitted to the hospital, including date of admission, reason for admission and discharge diagnosis, and date of discharge from hospital; and o For the last year, a list all individuals who have been admitted/transferred to the Facility's Infirmary, including date of admission/transfer, reason for admission/transfer, and date transferred back to residence. ▪ **Interviews with**: o Ingela Danielsson-Sanden, MD, PhD, MBA, Medical Director; o Norma Brown, MD; o Kusumakar Sooda, MD; and o Greg Walker, RN, Medical Program Compliance Nurse. ▪ **Observations of**: o Individual #101, Individual #260, Individual #122, Individual #215, Individual #232, Individual #15, Individual #126, Individual #161, Individual #340, Individual #303, Individual #278, Individual #366, Individual #57, Individual #22, Individual #212, Individual #124, Individual #183, Individual #342, Individual #43, Individual #189, Individual #160, Individual #93, Individual #280, Individual #24, Individual #207, Individual #70, Individual #150, Individual #270, Individual #307, Individual #16, Individual #276, Individual #274, Individual #272, Individual #23, Individual #25, Individual #229, Individual #134, Individual #299, Individual #350, Individual #301, Individual #50, Individual #113, Individual #181, Individual #236, Individual #293, Individual #354, Individual #37, Individual #127, Individual #68, Individual #314, Individual #32, Individual #319, Individual #179, Individual #209, Individual #356, and Individual #327; and o ICST (morning provider) meetings, on 10/1/13, 10/2/13, and 10/3/13.
	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: o The monitoring/audit tools the Facility used to conduct its self-assessment included: internal and external general medical audit and internal and external medical management audit, internal Medical Department audits for specific diseases (e.g., seizures, osteoporosis, hypertension, diabetes mellitus, Down's syndrome, and constipation). o These monitoring/audit tools included some of the necessary indicators to allow the

	Facility to determine specific aspects of 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. o The monitoring tools included adequate methodologies, such as record reviews. o 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. o Some of the monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. For other audits, information was not submitted concerning instructions or guidelines. o The following staff/positions were responsible for completing the audit tools: Medical Program Compliance Nurse. o The staff responsible for conducting the audits/monitoring had clinical experience in the relevant area(s). The Facility did not have processes in place to ensure that staff that completed monitoring were competent as monitors. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached, including: databases for annual medical assessments, osteopenia/osteoporosis diagnostic findings and treatment, mammograms, colonoscopies, quarterly medical reviews, off-campus appointment completion, and follow through of recommendations. o The quality of the data maintained in the databases was noted to be complete, but at times accuracy was a concern. There were several different databases submitted for pneumonia, but there were differences among the data provided. o Examples of databases/data sources that were not considered included tracking of the activities of the integrated clinical services meetings for closure of concerns, timeliness of open record reviews, and quality of ISPAs in response to a request from the integrated clinical services committee or post-hospital ISPAs. ▪ The Facility presented data in some meaningful/useful ways, but some problems were noted. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Did not measure the quality as well as presence of items. For instance, in Section I, there was the observation that the annual medical assessments were not addressing each of the risk areas identified in the Integrated Risk Rating Form (IRRF). Focus has been on timeliness of completion of documents, which is imperative. However, additional monitoring for quality of annual medical assessments and quarterly medical reviews is needed. ▪ The Facility rated itself as being in noncompliance with Section L. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided some analysis of the information. For other areas, the submitted documents reviewed by the Monitoring Team indicated findings that were not in agreement with

	the self-assessment, such as the findings per PCP of the medical management audit for pneumonia, as well as not listing justifiable diagnoses for some DNR orders.
	Summary of Monitor's Assessment: The Medical Department had made significant progress with numerous initiatives: ▪ The structure for the ICST meeting had been established, and routine updates by various members from clinical departments were included. However, the structure was in the early stages of implementation, and more work was necessary to ensure important topics were covered thoroughly, and teams developed appropriate follow-up ISPAs, particularly for hospitalized individuals. ▪ Several guidelines and protocols had been developed, including early aggressive treatment of unstable vital signs. ▪ Preventive care was one of the Medical Department's strengths, especially with the recent addition of gynecological services, as well as completion of such procedures as mammograms and colonoscopies. ▪ The internal quality audits appeared rigorous and current, and covered several diagnoses common to the Intellectual Disabilities/Developmental Disabilities (ID/DD) population. There were numerous challenges remaining: ▪ Some of the databases had conflicting data. ▪ The ICST needed to ensure timely completion of open record reviews and reviews of ISPAs. ▪ The quality of the ISPAs the ICST requested needed review. ▪ The annual medical assessments needed to include a discussion of the risk categories used in the IRRF. ▪ Some protocols, such as secondary causes of osteoporosis had not been implemented. ▪ In addition to timely completion, quarterly medical reviews needed standardization of content and focus efforts to improve the value and utility of the information included. ▪ Reduction in the number of missed specialty appointments should be considered. ▪ Do Not Resuscitate (DNR) Order status required further research to determine whether there was justification or not. ▪ The Facility had many databases that could be used to guide quality improvement initiatives in the Medical Department. It will be important to document the analysis of information in each of these databases, and then develop and implement action steps, and review outcomes to determine the effectiveness of the corrective actions.

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L1	Commencing within six months of the Effective Date	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,	Noncompliance

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	hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	medical management of acute and chronic conditions, and Do Not Resuscitate Orders. <u>Staffing and Administration</u> For the census of 244 individuals as of 7/31/13, there were four PCPs responsible for this population. There was a full-time Medical Director and three PCPs. The Medical Director did not have a caseload. Other PCPs had caseloads ranging from 38 to 79 individuals. The document entitled: "PCP Caseloads" indicated there were two staff PCPs and two contract PCPs. More recently, as of 10/1/13, there were three PCPs (one staff PCP and two contract PCPs) in addition to the Medical Director. As of this later date, the PCPs had assigned caseloads ranging from 59 to 100. The Medical Director did not have a caseload. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated 7/31/13. This list included current PCPs as well as other contract PCPs and staff PCPs not listed in the "PCP Caseloads" document dated 7/31/13. A total of eight PCPs were listed, along with the Medical Director. All were current in CPR. Of the five physicians (i.e., four PCPs and one Medical Director) in the Medical Department as of 7/31/13, a list of CME credits was submitted for two of these PCPs. This varied from seven to 21 hours. The topics covered included such clinical areas as abuse of pain relief medication, dementia and parkinsonian disorder, physical exercise and improved cognition in older patients, early detection in ovarian cancer, health-related risk factors associated with tooth loss, treatment of hallucinations in neurodegenerative diseases, diagnosis and treatment of epilepsy, obesity, back pain, drug prescribing in the elderly, falls, informed consent and do not resuscitate orders, nutritional syndrome, perioperative management of hyperthyroidism, perioperative management of rheumatic disease, screening of HIV, screening of osteoporosis, sepsis, and von Willebrand's disease. 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. The majority of the topics that were covered were areas of importance to primary care and the individuals residing at CCSSLC. In addition, the Medical Department began to hold monthly in-service sessions for the PCPs. Topics listed included wound care (5/13), a pharmacy update on guidelines for Vitamin D levels and proton pump inhibitors (6/14/13), and vagal nerve stimulator treatment for epilepsy (8/16/13). A signed roster of attendance with date of meetings was not submitted for any of these three in-services. <u>Physician Participation In Team Process</u> For the ICST, there was a signed roster, which circulated each morning. Copies of the minutes for each of three meetings a member of the Monitoring Team attended were requested, but not submitted. There was considerable lag time in sending dictation off-site for transcription. Submitted were the handouts provided each morning, with additional brief entries. The final morning minutes were not available to confirm observations of the Monitoring Team. The following reflects the observation of a member of the Monitoring Team: ▪ For the three morning medical meetings observed (i.e., on 10/1/13, 10/2/13, and 10/3/13), there was a signed attendance roster in three of three meetings.	

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		▪ For the three meetings observed, there were eight hospitalizations (i.e., Individual #21, Individual #319, Individual #205, Individual #130, Individual #79, Individual #239, Individual #4, and Individual #252). The Infirmary census was nine each of these three days. ▪ Hospital liaison nurse updates: The Hospital Nurse Liaison reported updates for individuals that had been hospitalized during three of three observed meetings. ▪ On-call PCP participation: For the meetings observed, the on-call PCP (from the prior evening) participated in presenting the cases in three of three meetings. ▪ The 24-hour campus coordinator log was reviewed three of three mornings. ▪ For one of three meetings, announcements were given. ▪ For zero of three meetings, medical/dental restraints were reviewed. ▪ Assignment of follow up to meeting participants: For one clinical discussion, critical clinical questions were raised and items needing closure were identified. As a result of this discussion, the Medical Director determined the need for a medical staff meeting. ▪ Formal record review: For none of the hospitalized individuals was there a request for a formal record review to determine preceding events, monitoring intensity, etc., before the onset of acute illness. ▪ Open record review: During one of three meetings, an open record review was discussed for Individual #340. ▪ 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 no assignments made to attendees for an open book review for the seven to 14 days prior to the illness to review monitoring of care, positioning documentation, feeding concerns, and 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 review of medication and medication side effects, etc. In comparing the list of already assigned open record reviews from prior meetings, there were three individuals with these clinical criteria (pneumonia, etc.) that would be anticipated to have an open record review assigned. ▪ Closure discussions: There were no prior assignments for follow-up that were presented at the morning meetings. At the start of the Monitoring Team's visits at the morning meetings, there were no outstanding concerns needing closure other than ISPA reviews and open record reviews. ▪ Review of requested ISPAs: There were three brief summaries of ISPAs that the group had assigned to IDTs in responding to concerns. These were discussed, and three of three were accepted as resolving/answering the concern. ▪ Infection control updates: During the three meetings, three infection control updates/information were presented. ▪ Summaries of completed consultations: During the three meetings, eight summaries were presented of completed consultations from the prior day. ▪ Dental Department updates: The Dental Department provided brief updates/information during zero of three meetings.	

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		▪ PT/OT/Speech Therapy (ST) and PNMT updates: The PT, OT, ST and PNMT presented updates during zero of three meetings. ▪ Skin integrity updates: Skin integrity reports/updates were provided at zero of three meetings. ▪ Discussion of significant weight change: There was a discussion of individuals with significant weight loss or gain at zero of three meetings. The strengths noted at the medical morning meeting included the following: Critical thinking concerning individuals on the 24-hour report and those hospitalized was evident in three of three meetings. Weakness and concerns included the following: Although the morning medical meeting structure was in place, it was in the early stages of implementation. There were delays in presentation of open record reviews. There was little time for closure concerns, ISPA review, and consult reviews, because the majority of time was devoted to discussing hospitalizations. For requested ISPAs, record reviews, closure concerns, etc., assigned due dates did not appear to be followed regularly. There were several open record reviews with due dates from the prior days that remained outstanding. The group needed to review ISPAs to ensure preventive steps were included in the action plans. <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 six months were omitted, leaving 248 individuals listed. For two individuals, there was no information or misinformation suggesting a typographical error or data entry error. For 246 individuals, there were dates of prior and current annual medical assessments listed. Of these, 190 out of 246 (77%) recent annual medical assessments were completed within 365 days of the prior assessment. For 20 individuals, copies 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 15 out of 20 (75%). ▪ 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 plans of care addressing each of the significant, current diagnoses in 20 of 20 (100%) assessments. ▪ For the 20 most recent annual medical assessments, 20 (100%) addressed smoking history. ▪ Family history was adequate/helpful in three of 20 (15%). ▪ A discussion of appropriateness for transition to the community was included in 20 of 20 (100%). As discussed in the Section I Presentation Book, the annual medical assessment was used as a reference in guiding the IDTs in review and decision-making concerning the high-risk health indicators discussed as part of the IRRF. The PCP was expected to address 16 risk areas of the IRRF for each individual. There was to be	

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		sufficient detail of the assessment provided for the high-risk areas, but also a contribution in all the 16 clinical areas. The Medical Director and Facility Administration should review this interpretation of the process and the approach to documentation to ensure the documentation format for this information is helpful to the IDTs. Collaboration with the Nursing Department will be important as both departments were assigned responsibility for many of these risk areas. Input from the QIDPs in creating a user-friendly document for risk rating and justification of the risk rating would be valuable to ensure their concerns were addressed in creating a high quality IRRF. It is recommended that there be additional discussion among the medical staff concerning the requirement to include all 16 risk areas in the annual medical assessment, including input about the location in the annual medical assessment and the quality/content of the entries. Adding this additional documentation requirement as measured in the QA tool for Section I might create new challenges in timely completion of the annual medical assessments. Having a separate form to address the highest risk areas might allow the timely completion of the annual medical assessments to move forward, and provide the quality background information the IDTs need. This might provide an opportunity to have such a form completed during discussion between the PCP with the RN Case Manager to specifically address these risk areas, rather than each completing a risk assessment separately. As part of the monitoring review process, the Monitoring Team selected the medical records of 10 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The sample was selected by identifying individuals with various diagnoses/health care issues from each risk category (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This sample was done to allow the Monitoring Team to review the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included preventive care flow sheets, physician orders for the prior one year, IPN for the prior one year, the most recent three quarterly medical reviews, the most recent BSP, last annual ISP and subsequent addendums, labs, x-rays/CT scans, MRI scans, ultrasound scans, other radiographic test results for the prior one 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, 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 these 10 medical records reviewed: ▪ As of 9/30/13, 10 of 10 (100%) annual medical assessments had been completed in the prior 365 days. ▪ Active problem lists appeared to be thorough in nine of 10 (90%). ▪ Ten of 10 (100%) annual medical assessments included a review of smoking history and/or substance abuse history. ▪ A family history was documented (or attempts at obtaining this information) in four of 10 (40%) records. ▪ Ten of 10 (100%) had information discussing appropriateness for transition.	

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		These 10 medical records also were reviewed to determine whether the physician IPN note used the Subjective, Objective, Assessment, and Plan (SOAP) format for acute illness documentation. In 10 of 10 (100%), the SOAP format was used. ▪ Ten of 10 (100%) of SOAP IPNs included the date. ▪ Ten of 10 (100%) of SOAP IPNs included the time. ▪ Five of 10 (50%) of SOAP IPNs recorded vital signs or referenced vital signs from a prior note. The Medical Department provided a list of quarterly medical reviews (and annuals if completed in a month in which a quarterly was due) that were completed each quarter for all individuals. Information for 236 individuals was provided. Information for five individuals was repeated and the duplicates removed. Based on submitted information for these 236 individuals, for two quarters, for compliance, there would be a total of 472 quarterlies or quarterlies and annuals substituting for the quarterlies during this time interval. Two hundred twenty five quarterlies and seven annuals were listed, for a compliance rate of 49 percent (232/472). From the 10 medical records reviewed, one record had no quarterly reviews submitted for 2013. One record had one quarterly medical review for 2013. Seven records had two quarterly medical reviews for 2013, and one record had three quarterly medical reviews completed. When including the date of the annual medical assessment when it fell in a quarter without a quarterly medical review completed, two of 10 (20%) had a quarterly medical review or annual exam completed each quarter of 2013. Separately, contents of the quarterly medical review for 30 individuals were reviewed for completeness and timeliness. For timeliness the following information was noted for 51 submitted quarterly medical reviews for these 30 individuals: ▪ Using a cut-off date of 8/31/13, for the most recent quarterly medical review submitted, 39 of 51 (76%) were timely in completion. ▪ For the quarterly medical review completed prior to the most recent quarterly medical review, 34 of 51 (67%) were timely in completion. ▪ Four were undated. ▪ Although one might anticipate 60 quarterly medical reviews for 30 individuals, CCSSLC also utilized timely annual medical assessments to replace one quarterly medical review at the time of its annual due date. It was not known whether this occurred for the nine individuals for whom only one medical quarterly review was submitted. All PCPs used a template format was. The two most recently completed quarterly medical reviews were submitted for each of the 30 individuals and 51 quarterly medical reviews were assessed for content. ▪ A template was utilized/completed in 51 of 51 (100%) quarterly medical reviews. ▪ For 47 of 51 (92%) reviewed, the date of the quarterly review completion was included. ▪ New or major diagnoses were listed in 21 of 51 quarterly medical reviews. The template listed "new active problems in last 3 months." It also listed "see updated Active Problem List," which	

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		appeared to prompt the PCP to add any changes to the Active Problem List. However, this was not helpful in providing information on the quarterly medical review, as the Active Problem List was a separate document. ▪ The last three monthly weights or equivalent information were recorded in 31 of 51 (61%) quarterly medical reviews. ▪ There were brief comments/entries listing numbers of seizures (if applicable) in 28 quarterly medical reviews. ▪ There was documentation of changes in medication in 33 of 51 quarterly medical reviews. ▪ Important/abnormal labs and drug levels/radiographic test results were documented in 39 of 51 quarterly medical reviews. ▪ Four individuals had documentation of an ER visit. Four of four (100%) included reasons for the ER visit. Zero of four (0%) included treatment provided in the ER. ▪ Six individuals had documentation of hospitalization. Five of six (83%) included reasons for the hospitalization. One of six (17%) included treatment during the hospitalization. ▪ There was documentation that consultations had occurred in 41 of 51 quarterly medical reviews. The type of consult was recorded in 40 of 41. A few observations were made. Some of the prompts on the template appeared to be confusing and not helpful, such as "see updated consult list" or "see updated active problem list." One of the purposes for the quarterly medical review was providing a capsule summary in one document of important health issues in the prior 90 days. This would be of most value for the covering or on-call physician in obtaining recent prior medical history, as well as a synopsis for IDT members concerning health issues. Referencing other areas of the active record instead of providing information in the quarterly medical review was unhelpful. Providing evidence of review of serial weights in the prior quarter was problematic. Some PCPs listed one weight, and some listed a range. The PCP needed to demonstrate a review of weights to determine any significant, recent weight changes. The quarterly medical reviews did not provide sufficient information concerning significant findings or recommendations of the consultants. Important results should be documented on the quarterly medical review briefly, and the document should be a stand-alone document. It appeared there was need to provide guidance in completing a quarterly medical review to ensure standardized contents, and a monitoring tool needed to be implemented to track the quality of the content. <u>Access to Specialists</u> The following charts indicate the off-site appointments scheduled, the off-site appointments completed, follow-up appointments scheduled, follow-up appointments completed, and pending appointments based on data the Facility submitted. The information was not dated, but appeared to go through July 30, 2013. Information provided was for appointments beginning in February 2013.	

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Specialty	Initial Appointment Scheduled	Initial Appointment Completed	Number of Appointments Rescheduled	Follow-up Initial Appointment Completed	Pending	Percent Completion or Order Discontinued*
Dermatology	15	12	3	2	1	14/15 = 93%
Cardiology	47	32	20	10	5	42/47 = 89%
Nephrology	7	2	5	3	2	5/7 = 71%
ENT	36	24	13	7	4	32/36 = 89%
Ophthalmology	133	94	40	15	22	109/133 = 82%
Podiatry	57	44	14	12	0	56/57 = 98%
Pulmonary	17	10	6	5	2	15/17 = 88%
Oral Surgery	10	7	5	3	0	10/10 = 100%
Urology	32	22	12	6	4	28/32 = 88%

*Due to transition to community, death, or other reason determined by PCP or IDT.

The submitted information was detailed, but appeared to have considerable errors. There were follow-up dates to complete an initial appointment that had occurred earlier than the initial appointment. Some follow-up appointments were listed as a range of time rather than a day. The Cardiology consult list appeared to be missing a page. The above information was derived from this data, but was reviewed to determine the number of initial appointments that were eventually completed. It is recommended that this statistic be included in the Medical Department QI program and tracking system, as well as for future quarterly reports. It is also important to review and improve the quality and completeness of the database. Not all off-site appointments were included for review, but the chart above referenced specific specialty appointments. However, some specialties, such as gastroenterology, were not represented in the data.

On-site, specialty clinics were held to meet the needs of the individuals. The following chart shows this information from February 2013 through July 2013.

Specialty	**Date of clinic**	**Appointments Scheduled**	**Appointments Completed**	**Follow-up to Prior Appointment Scheduled**
Neurology	2/2/13	22	21	
Neurology	3/2/13	16	15	
Neurology	4/27/13	26	26*	1 (from 2/2/13)
Neurology	6/22/13	29	28	
Orthopedics	4/17/13	8	8	

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*One individual did not show for the appointment but a record consult was completed.

The quality of the consultation referrals is reviewed as part of the peer review process. 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 with regard to Section G.2.

The Medical Department submitted a list of all medical appointments made on-campus and off-site, as well as a list of all missed appointments, with reasons. For both on-campus and off-site appointments, a total of 1077 appointments were made. Of these, 1077 initial appointments, 844 were completed (78%). The following provides the number of missed appointments for all causes by month:

Month	Number of missed appointments	Month	Number of missed appointments
February 2013	40	May 2013	35
March 2013	42	June 2013	21
April 2013	40	July 2013	42

The following lists the total number of missed appointments due to the most common reasons:

Reason for missed appointment	Number of missed appointments
Specialist office cancelled	29
Illness of individual	9
Refused	25
Uncooperative behavior	18
Scabies outbreak	20
No transportation	7
Administrative reasons – paperwork not prepared, schedule conflict, etc.	23
No reason given	76

Seventy-six of 233 (33%) missed appointments had no reason given. It is recommended that this be reviewed and systems implemented to correctly record the reason for each missed appointment as an initial step in reducing the number of missed appointments. Further analysis should be completed of the common reasons, and, where appropriate, actions should be implemented to reduce to the extent possible the numbers of missed appointments.

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		Preventive Care ▪ Preventive care flow sheets were available to facilitate tracking of standard testing and evaluations in 10 out of 10 (100%) records reviewed. ▪ Preventive care flow sheets were up-to-date in eight out of 10 (80%) records reviewed. ▪ As of 8/31/13, current vision screening was documented within the prior 12 months in eight of 10 (80%) records reviewed, and in nine of 10 (90%) within the prior 24 months. ▪ As of 8/31/13, audiological screening occurred in five of 10 (50%) records in the prior year, in nine of 10 (90%) records in the prior two years, and in 10 of 10 (100%) records in the prior three years. ▪ The influenza vaccination had been given to 10 of 10 individuals (100%) in a timely manner during 2012. ▪ Whether the individual needed to receive varicella vaccine (i.e., depending on birth date and immunity status), and whether it was given if indicated, was recorded in nine of the 10 (90%) active records reviewed. ▪ From submitted documentation, whether the individual needed to receive a hepatitis B vaccine (i.e., depending on immunity status, carrier state, immune responsiveness to completed series, etc.) and whether the series was completed if indicated (or being tracked for completion), was recorded in nine of the 10 (90%) active records reviewed. ▪ A Tdap was recorded as given in six of 10 (60%), although documentation at times needed further clarification of administration of Tdap, or other tetanus vaccination without pertussis vaccination for adults. ▪ A pneumococcal vaccination had been given to 10 of 10 (100%). ▪ For individuals age 60 or over, a zoster vaccine had been given to two of three (67%). The minutes of the July 24, 2013 Infection Control Committee meeting documented that the immunization records of all individuals were being reviewed to ensure accurate information. This included a review of the old immunization records, the infection control immunization database, and the AVATAR immunization database. This project was expected to be completed by September 30, 2013. A list was submitted indicating women residing at CCSSLC who were over the age of 40, along with the date of last mammogram, and the reason if it was not done or outdated. A total of 94 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, 16 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, etc.). For two women, the information provided did not indicate an accurate date of a prior mammogram. Of the remaining 74 women, 72 had mammograms within the prior year. This was a compliance rate of 72 out of 74 (97%). It was noted that there were two women aged 70 or greater. Of these, one had reasons for not completing a mammogram. Of the one remaining woman over 70, one had a mammogram completed during 2013. From the sample of 10 medical records reviews, there were five females between the ages of 40 and 70. Of these, five females were eligible for a yearly mammogram (i.e., no contraindication or reason for not	

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		completing a mammogram). As of 8/31/13, five of five (100%) were up-to-date on mammogram testing. From the sample of 10 active records reviewed, there were five females between the ages of 21 and 65. One of five (20%) females had pap smears completed within the prior three years. A list of all females age 21 and older was provided. The list included 103 individuals and the dates of their last pap smears. The ages of each individual were provided. Eighteen of 103 females (17%) had documentation of cervical cancer screening within the prior three years. Twenty-two of 103 females (21%) had documentation of cervical cancer screening within the prior five years. Of the 22 pap smear results, 19 were considered normal. Nineteen of the 22 had a pelvic exam recorded. For 28 of 103, there was no information or record of a prior pap smear. Eight individuals had undergone hysterectomy. Five of the hysterectomies were for benign pathology, one for malignancy, and for two cases, no information was submitted. The Medical Department recently had contracted for gynecology services and as a result, there had been recent improvement in rates of completion of pap smears and pelvic exams on applicable individuals. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 132 names were submitted. Of these, four were over the age of 75. As it takes time to schedule visits and procedures and have the IDT discuss procedures and potential complications of the prep involved, the two individuals at age 50 who had not completed a colonoscopy were removed from the list of those for whom a colonoscopy would be expected to have been completed. Thirty-one had a colonoscopy completed for active problems and not preventive care and were excluded. Seven had clinical contraindications or family/guardian refusals of consent. Therefore, the eligible population for a preventive colonoscopy totaled 88 individuals. Of these, 86 of 88 (98%) completed a colonoscopy within the prior 10 years, and/or had alternate testing considered acceptable as clinical equivalents. Of the four individuals over the age of 75, four of four (100%) had completed this procedure within the prior 10 years. In summary, 117 individuals completed colonoscopies in the prior 10 years, 86 as a preventive test (74%) and 31 as a diagnostic test (26%) for an active problem. Of the 10 active records reviewed, there were six individuals from the age of 50 to 75. Zero of these were currently age 50, and would not necessarily have had a colonoscopy completed at the time of the active record review. One individual was over the age of 75. Of the six eligible individuals, zero had a clinical reason for not pursuing a colonoscopy. Six of six (100%) had a colonoscopy completed in the past 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 also was requested. Additionally, for all those over 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were submitted. 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 as an important parameter in determining the severity of disease,	

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		treatment would be ordered to optimally treat the individual. Follow-up DEXAs to determine T-scores are indicated at intervals (every two to three years) to determine effectiveness of treatment. A total of 115 individuals with a potential diagnosis of osteopenia or osteoporosis were reviewed. Of these, 114 had a DEXA scan submitted. The one individual without a DEXA scan result was removed from the list. Two others had normal T-score values, indicating lack of osteopenia and osteoporosis. The remaining 112 had either osteoporosis or osteopenia. ▪ One hundred eight of the 112 (96%) DEXA scans were considered current (i.e., completed within the prior three years from 8/31/13). ▪ One hundred individuals had osteoporosis and 12 had osteopenia. ▪ Eighty-seven of 100 (87%) with osteoporosis were treated with a bisphosphonate or alternative medication to treat or prevent osteoporosis. ▪ One hundred two of 112 (91%) with osteoporosis or osteopenia were treated with calcium supplementation. ▪ One hundred two of 112 (91%) with osteoporosis or osteopenia were treated with Vitamin D supplementation. For men with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Forty-six men were determined to have osteoporosis or osteopenia. The Medical Department had created a "Guideline for Evaluation of Osteoporosis and secondary causes of osteoporosis." The following lists compliance with several of these tests recommended in the guideline and was based on the submitted information: ▪ Two of 46 had a testosterone level recorded. ▪ Forty of 46 had renal function recorded. ▪ Thirty-five of 46 had liver function recorded. ▪ Eight of 46 had thyroid function recorded. ▪ Thirty-nine of 46 had a Complete Blood Count (CBC) recorded. ▪ Forty of 46 had a calcium level recorded. Additionally, although not listed in the initial evaluation for secondary causes of osteoporosis, a Vitamin D level was recommended for those at high risk of Vitamin D deficiency. Forty-two of 46 men had a Vitamin D level recorded. For women with a diagnosis of osteoporosis/osteopenia, the Medical Department submitted laboratory results from the current active record as part of the evaluation for secondary causes of osteoporosis. Sixty-four women were determined to have osteoporosis or osteopenia. The Medical Department had created a "Guideline for Evaluation of Osteoporosis and secondary causes of osteoporosis." The following lists the compliance with several of these tests recommended in the guideline and is based on the submitted information: ▪ Sixty of 64 women had renal function recorded. ▪ Fifty-seven of 64 women had liver function recorded.	

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		▪ Four of 64 women had thyroid function recorded. ▪ Sixty-one of 64 women had a CBC recorded. ▪ Sixty of 64 women had a calcium level recorded. Additionally, although not listed in the initial evaluation for secondary causes of osteoporosis, a Vitamin D level was recommended for those at high risk of Vitamin D deficiency. Sixty-one of 64 women had a Vitamin D level recorded. The Medical Director communicated that the osteoporosis guideline "Osteoporosis Evaluation" had not been in-serviced or implemented at the time of the Monitoring Team's visit. In that context, the above information was considered a baseline to determine future impact of the guideline and to track change in evaluation of the cause of the osteoporosis. The development of this guideline was a positive development. A number of steps had been taken to determine the daily intake of calcium and Vitamin D by each individual. This would be important, as the PCP would then be able to order the appropriate amount of supplemental Vitamin D or calcium. A task force entitled "RDA Calcium and Vitamin D work group" met on 5/8/13 at the Medical Director's request to review the adequacy of recommendations for calcium and Vitamin D in individuals with osteoporosis, individuals with osteopenia, and individuals with no disease. The goal was to develop a form and procedure for the dietician to calculate daily intake of calcium and Vitamin D in the diet that would be recorded on the Annual Nutritional Evaluation. Several action steps took place, including review of updated literature, addition of calcium and Vitamin D information in an individual's Annual Nutritional Evaluation, notification of Facility Administration of the updated State menus not being used at CCSSLC, and implementing updated menus. On 6/18/13, a follow-up meeting was held. At that time, the group decided to invite the Food Service Director to attend the next meeting. The Annual Nutritional Evaluation was to include the amount of calcium the individual was receiving as well as evaluate the Vitamin D status based on current lab values, with recommendations as appropriate. According to the Clinical Pharmacist, the Facility was required to obtain an annual Vitamin D level. Reference to this requirement was not included in the minutes. The Clinical Pharmacist recommended that individuals greater than 60 years of age receive a Vitamin D supplement. At the 6/27/13 follow-up meeting, the Food Service Director communicated that updating the menus might create waste. The current menus at CCSSLC contained items the residents were known to like. The Food Service Director also indicated that adding milk to meals twice a day was a feasible step to meet the recommended daily allowance for calcium. The dieticians were going to review the menus and determine differences in menu options and nutritional values. Recommendations from national guidelines were reviewed for daily calcium and Vitamin D amounts for individuals according to age. The physician was to then determine the necessity of additional supplementation. An example of the nutritional content of a meal provided to individuals at CCSSLC was submitted. It included considerable detail in the amount of nutritional components, including Vitamin D and calcium. The example provided was a "1000 calorie master menu 2010-2011; with snack not included." In this menu report, the total daily average calcium was calculated to be 902 mg and the total Vitamin D was 256	

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		International Units (IUs). The analysis also included the Dietary Reference Intake (DRIs), which listed the daily recommended allowance for each listed nutrient component, along with the percentage of the DRI, which was provided by this menu. Several QDRRs also were submitted, in which it appeared the Clinical Pharmacist recommended a reduction of calcium intake based on a normal calcium level. This was not supported by references included with the documents of the task force. There also was mention of potential reduction of constipation side effects. The reference included the daily calcium intake per age group based on the diet and supplements as an important clinical goal. To provide clarity to this issue, it is recommended the Medical Director review the literature concerning the pharmacy recommendation noted above. An additional notation as to the average amount of the diet consumed at each meal by the individual would determine the need for an adjustment in the daily intake of calcium and of Vitamin D. A calculation by the Clinical Pharmacist of the amount of calcium and Vitamin D in the supplements (including multivitamins with therapeutic minerals) would provide the amount already prescribed for the individual. This did not appear to be clearly calculated in all the QDRR examples provided and readily available to the PCP. The combination of information about the dietary intake from the Dietician and pharmaceutical supplements from the Pharmacy would provide the needed information for the PCP to determine whether a change in order was needed, based on a diagnosis of osteoporosis, osteopenia, age, and other factors. This taskforce appeared to address some of these areas. The Medical Department is encouraged to maintain an ongoing list/database of the intake for each individual of calcium and Vitamin D in the diet/formula, as well as all supplements, along with whether the individual has osteoporosis or osteopenia, and age, and with additional comments for pertinent history (i.e., renal stones, history of hypercalcemia, hyperparathyroidism, etc.). Currently, there were a few individuals provided three to four grams of calcium per day, and there was no database available for quality review. Likewise, there were several individuals with low Vitamin D levels, but one was on no supplement, and for several, there was no information indicating an increase in supplementation was ordered. Creating a database with readily available information would allow quality assurance of the appropriate ordering of calcium and Vitamin D in those with osteoporosis and osteopenia. A sample of 73 "Annual Nutritional Evaluations" was reviewed to determine content. Of these, 70 individuals were given Vitamin D supplementation. For one of the three remaining individuals, the Vitamin D level was considered low, yet the individual had no supplementation. For the 70 individuals prescribed Vitamin D, the amount prescribed was not indicated in the "Annual Nutritional Evaluations." Daily calcium intake from the diet (either prior or new recommended diet if there was a change) was recorded in 51 of 73 (70%) evaluations. The daily amount of Vitamin D intake from the diet was recorded in one of 73 (1%). This number appeared to be readily available according to the nutritional analysis of the master menu, and would be easily incorporated into the nutritional evaluation. No information was provided as to the amount of calcium (in mg) ordered through additional supplementation, although the evaluations did indicate when the calcium supplementation was provided. Sixty-four individuals were ordered a multivitamin, but no information was provided as to the amount of calcium or Vitamin D in the multivitamin.	

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From the sample of 10 medical records reviewed, eight had a diagnosis of osteopenia or osteoporosis. Seven had completed a DEXA scan. For one individual, a DEXA scan had been ordered, but there was no information indicating it had been completed. Seven of these DEXA scans were completed in the prior three years (from 8/31/13).

- Of these, for seven documented completed DEXA scans, seven (100%) had a DEXA scan/T-score recorded.
- Of these seven, seven (100%) had a T-score consistent with the diagnosis of osteoporosis or osteopenia.
- Of the eight with a diagnosis of osteoporosis or osteopenia, eight (100%) had been prescribed supplemental calcium and Vitamin D.
- Of these, six had a bisphosphonate ordered.
- Of these, one had Miacalcin prescribed.

Down syndrome and hypothyroidism
A 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. As of 7/31/13, 11 of 11 (100%) had a thyroid test completed within the prior 12 months.

Acute and Emergency Care
Documentation was provided for Emergency Room visits from February 1, 2013 through July 31, 2013. The following table lists the analysis of this raw data by month, the number of emergency room visits for the month, and the most frequent/common categories of diagnosis for the visits, based on the submitted documentation:

Month	Number of ER Visits	Trauma	GI	Respiratory	Neur-ology	Infection	Cardio-vascular	Bleed-ing	Other
2/13	11	1	2	2	1	0	1	1	3
3/13	5	0	2	1	1	1	0	0	0
4/13	5	0	2	1	0	0	0	0	2
5/13	12	1	1	8	0	1	0	0	1
6/13	12	3	2	2	1	1	0	0	3
7/13	8	1	4	3	0	0	0	0	0
Total	**53**	**6**	**13**	**17**	**3**	**3**	**1**	**1**	**9**

The active record was reviewed for 10 individuals who had most recently gone to the ER and returned. These individuals are listed in the documents reviewed section. Eight of the 10 had gone to the ER from their residence. Two had gone from the Infirmary to the ER.

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The following summarizes the results of this review:

- Information was submitted indicating that the ER was notified prior to the arrival of the individual with appropriate medical background information provided for nine of 10 (90%) individuals.
- Prior to the transfer to the ER, a PCP was on-site for five of these transfers. In four of five (80%) records, the PCP had written an IPN that included the date and time.
- For one of four (25%) PCP transfer IPNs, vital signs were recorded.
- For four of four (100%) PCP transfer IPNs, reason for the transfer was documented.
- In four of the four (100%) PCP transfer IPNs, the SOAP format was utilized.
- A copy of the ER report was available in zero of 10 (0%). For one of 10, lab and test results were submitted, but no ER report. Copies of patient instructions from the ER were available in 10 of 10 records. However, this did not provide information as to the diagnostic evaluation, and treatment in the ER.
- Of the 10 ER visits, diagnostic categories included: Trauma (five), Respiratory (one), Pica (one), and GI (three).
- When the individual returned to the Facility after evaluation at the ER, seven of the 10 (70%) active records had a PCP IPN.
- Seven of seven (100%) post-ER visit PCP IPNs included date and time.
- Two of seven (29%) post-ER visit PCP IPNs included recording of vital signs.
- Seven of seven (100%) post-ER visit PCP IPNs utilized a SOAP format.
- A summary of ER information and findings was included in seven of seven (100%) PCP IPNs.
- When returning to the Facility, nine returned to the individual's residence, and one returned to the Infirmary.
- For 10 of 10, treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER.

Documentation was provided for hospitalizations from February 1, 2013 through July 31, 2013. The following lists the month, the number of hospital admissions per month, and the most common/frequent categories of diagnosis for the visits, based on the submitted raw data:

Month	Number of admissions	Respiratory	Neur-ology	Genitour-inary (GU)	Gastro-enterology (GI)	Bleeding	Infection	Other
2/13	8	3	0	0	2	1	0	2
3/13	8	3	0	0	4	0	1	0
4/13	16	7	0	0	5	0	2	2
5/13	12	8	0	1	1	0	1	1
6/13	7	2	1	0	2	0	1	1
7/13	7	3	0	0	4	0	0	0
Total	**58**	**26**	**1**	**1**	**18**	**1**	**5**	**6**

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Additionally, 10 active records were reviewed for those individuals admitted to the hospital. The following provide the results of this review:

- Ten individuals returned to the Facility. No individuals died while in the hospital. Nine of 10 (90%) had PCP IPNs post hospitalization.
- Of the nine post-hospital PCP IPNs submitted, five (56%) included vital signs.
- Nine of nine (100%) post-hospital PCP IPNs included date and time.
- Nine of nine (100%) post-hospital PCP IPNs had an adequate summary of hospital events and findings.
- Eight of nine (89%) 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.
- Eight of 10 (80%) active records included a copy of the hospital discharge summary.
- Nine of 10 (90%) active records included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. One of 10 included neither a hospital admission history and physical or a hospital discharge summary.
- Ten of the 10 (100%) included Hospital Liaison Nurse notes for the individuals.
- For seven of the 10 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 of the admitting diagnoses included the following: respiratory (4), gastrointestinal (2), neurological (1), pica (2) and metabolic (1).

CCSSLC had an Infirmary. Documentation was provided for Infirmary admissions from February 1, 2013 through July 31, 2013. The following lists the month, the number of Infirmary admissions for the month, and the most frequent/common category of diagnosis for the admission, based on submitted data:

Month	Number of admissions	Trauma	GI	Respir-atory	Infec-tion	Fever	Metabolic / endo-crinology	Neur-ology	Dental / Post-op	Other
2/13	8	0	3	1	0	O	3	0	0	1
3/13	14	0	6	5	1	0	2	0	0	0
4/13	35	2	9	4	2	2	10	2	3	1
5/13	21	0	4	10	2	2	2	0	1	0
6/13	14	0	1	4	3	1	3	1	1	0
7/13	11	0	0	3	2	2	1	2	0	1
Total	**103**	**2**	**23**	**27**	**10**	**7**	**21**	**5**	**5**	**3**

For those that were discharged from the Infirmary, the length of stay varied from less than one day to 37 days.

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		▪ The number staying one day or less was 46. ▪ The number staying two days was 12. ▪ The number staying three days was 10. ▪ The number staying four days was seven. ▪ The number staying five days was seven. ▪ The number staying six days was four. ▪ The number staying seven to 10 days was six. ▪ The number staying 11 to 20 days was three. ▪ The number staying 21 to 30 days was one. ▪ The number staying 31 to 60 days was three. ▪ The number staying 61 or more days was zero. *Pneumonia* Data was submitted that had been entered into the Avatar database. Information concerning pneumonias was submitted for the time period February 25, 2013 through July 12, 2013. According to this database, there were 20 pneumonias during this time period in 19 individuals. Of these 20 pneumonias, four were categorized as aspiration pneumonia. Off-site physicians diagnosed eighteen of these 20 pneumonias. As part of confirmation of the diagnosis of pneumonia, the following information was provided in this database. Twenty of 20 had a chest x-ray completed. For 17 of these 20, the chest x-ray confirmed an infiltrate. According to the database, four individuals were taking by mouth (PO) nutrition at the time of the pneumonia. For three of four, there was documentation of a therapeutic diet with varying textures and fluid thickenings. Fourteen of the 19 individuals had a feeding tube prior to the onset of the pneumonia. Twelve of the 14 had gastrostomy tubes (G-tube), one had a gastrojejunostomy tube (G/J-tube), and one had a jejunostomy tube (J-tube). The formula flow rate for those with gastro-jejunostomy tubes and jejunostomy tubes was continuous in one of two. For those with gastrostomy tubes, six utilized an intermittent flow rate, and five utilized bolus feedings. For one individual, the flow rate was not submitted. The incidence per month from the Avatar database was as follows: **Month** / **Number of pneumonia cases** / **Number of aspiration pneumonias** / **Number of bacterial pneumonias** February 2013: 2 / 1 / 1 March 2013: 4 / 1 / 3 April 2013: 2 / 0 / 2 May 2013: 4 / 0 / 4 June 2013: 4 / 1 / 3 July 2013: 4 / 1 / 3 **Total: 20 / 4 / 16** A separate document entitled "Individuals dining by mouth diagnosed with pneumonia 2/1/13 -7/1/13,"	

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		listed five individuals with PO nutritional intake, rather than the four listed in the Avatar database. One additional individual diagnosed with bacterial pneumonia was on a ground/pureed diet with pudding thick liquids, but was not on the Avatar list of individuals who had pneumonia. Separately, the number of new cases of pneumonia was listed in a document entitled "Individuals diagnosed with pneumonia."	

Month	Number of pneumonia cases	Month	Number of pneumonia cases
February 2013	2	May 2013	4
March 2013	4	June 2013	3
April 2013	3	July 2013	4
Total = 20			

The data submitted indicated duplication in one individual and that individual was removed. Four individuals had recurrent sepsis two to four weeks apart. This would be an opportunity for review of the active record, with a protocol for increased monitoring and other steps to prevent a recurrence.

A third document was submitted which listed the names of individuals with pneumonia and the dates of diagnosis over the prior year. This document was untitled, but provided the following information concerning the number of pneumonia cases per month:

Month	Number of pneumonia cases	Month	Number of pneumonia cases
February 2013	1	May 2013	4
March 2013	4	June 2013	4
April 2013	3	July 2013	4
Total = 20			

In this document, for the months of May and June, the entries were duplicated, and were removed before completing the chart above. It is recommended that the Medical Department review this information to correct errors of duplication, etc. These errors suggested a lack of monitoring and review by the Medical Department and other departments at the Facility.

A fourth document provided a trend over the prior year for pneumonia. Over the past year, there were 25 bacterial pneumonias, five aspiration pneumonias, and one viral pneumonia, for a total of 31 diagnosed pneumonias. For a comparison of the data from recent months with the databases mentioned in this section, the number of pneumonia cases per month were recorded as follows (derived from the graph of "infections by month"):

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Month	Number of pneumonia cases	Month	Number of pneumonia cases
February 2013	1	May 2013	3
March 2013	3	June 2013	2
April 2013	3	July 2013	1
Total = 13			

This information was different from one or more prior documents. From these various database sources, the numbers of pneumonia cases identified varied per month. The reason for the discrepancy was not determined. It is recommended that the data from these various sources be reviewed to determine the reason for the differences, and to systemically resolve data discrepancies.

To minimize the development of pneumonias, the Infection Control committee minutes of March 25, 2013 documented that environmental surveys were to be completed monthly, but were not being done. The July 24, 2013 Infection Control meeting minutes indicated that the environmental surveys were not being done consistently. It also was indicated in these minutes that the rate of influenza vaccination among employees had increased markedly from the prior year, from 39 percent to 80 percent. The infection control staff completed audits of nursing care plans for March through June 2013, and these were described as "overall are not adequate." The infection control staff provided feedback to the nurses creating the nursing care plans.

Respiratory therapy trained several staff (RNs) on the topic of nasopharyngeal suctioning. A competency-based checklist was submitted listing indications, contraindications, and hazards. It also listed 20 steps, which were used to ensure demonstration of the skill. Six completed training records for the "Competency Checklist: performing naso-tracheal suctioning" were submitted. These trainings were completed in July and September 2013. It was not determined whether additional staff had been trained.

Sepsis
Thirteen individuals were diagnosed with sepsis in the time period from February 1, 2013 through July 31, 2013. The following table provides the breakdown per month:

Month	Number of sepsis cases	Month	Number of sepsis cases
February 2013	0	May 2013	3
March 2013	1	June 2013	5
April 2013	2	July 2013	2
Total = 13			

Data from an infection control database did not record any cases of sepsis when that category was listed (entitled "Infection Type – Sepsis - fever of unknown origin") for two time periods: 2/1/13 to 4/30/13 and

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		5/1/13 to 7/31/13. This document was dated 8/6/13. An initiative was undertaken by the Medical Director to reduce the incidence of death by sepsis, pneumonia and other infections. A document was created entitled: "Guidelines for Infirmary Observation for Fever or Unstable Vital Signs." This provided specific guidance when a PCP should transfer an individual to the Infirmary. This listed parameters of vital signs, additional potential symptoms, the Infirmary evaluation to be completed by the nurse, and Infirmary laboratory testing to be completed. Additionally, if the individual had clinical decline/instability in the Infirmary, time parameters were given when the PCP was expected to respond and when the PCP was to examine the individual. Discussion with the Medical Director focused on the impact of this process. At the time of the Monitoring Team's visit, several individuals had been admitted to the hospital. It was noted that in the prior six months the number of deaths at CCLSSLC had decreased from prior months and years. However, it is important to note that the impact of this guideline, to move individuals to the Infirmary for close monitoring, was not known. The intended impact was to reduce mortality. It also might lead to hospitalization at an earlier time in the clinical illness, which might allow earlier medical intervention and potentially increased survival. The protocol was new and it will take several quarters of data to determine whether it has any impact. However, in order for this to have a positive impact on acute illness, Unit nurses will need to complete timely and accurate nursing assessments per the nursing protocols. Such assessment and notification of the PCP of the change in status is a necessary first step to trigger the use of the guidelines. As noted with regard to Section M, nurses often were not following or were not documenting implementation of the nursing protocols. *Trauma* During the time period from April 2013 forward, there were six fractures in six individuals. There was no event in which more than one fracture occurred. The fracture site included the following: nasal fracture, phalanx (finger), coccyx, fibula, ankle, and metatarsal (foot). From a document entitled "Injuries requiring visit to ER or hospitalization," during the time period from February 1, 2013 through July 31, 2013, six individuals went to the ER or were hospitalized for injuries. Five were for lacerations, and one was for a head injury. This document did not indicate an ER visit or hospitalization for a fracture. <u>Chronic Conditions and Specific Diagnostic Categories</u> *GERD* As part of the review of 10 medical records, GERD was reviewed. ▪ Of the 10, eight were diagnosed with GERD. For the following, not each case would have had the listed test or procedure, but this information provided evidence of the spectrum of treatment at the Facility, or lack thereof. ▪ Of these eight individuals, for five, an Esophagogastroduodenoscopies (EGD) or Upper Gastrointestinal (UGI) report were available or discussed in the IPN/ISP, or annual medical	

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		assessment. ▪ Of these eight, zero had mention of a fundoplication. ▪ Of these eight, seven had a feeding tube. Seven of seven were G-tubes. Zero of seven were J-tubes. ▪ Of these eight, eight had appropriate medication prescribed. ▪ Two of eight appeared to have significant GERD, which needed further review, (i.e., formula found in mouth, repeated aspiration, and rapid breathing pattern noted after bathing). There appeared to be no documentation of severity of GERD, or additional steps to be considered for these two individuals. ▪ Six of eight appeared to be stable clinically with treatment of GERD. ▪ Care was considered to follow clinical guidelines/national standards for evaluation and treatment of GERD in six of eight reviews (75%). *Tracheostomies* Six individuals currently had tracheostomies. *Newly diagnosed Chronic conditions* Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. One individual was newly diagnosed with diabetes mellitus. One individual was newly diagnosed with cardiovascular disease. No cases of a newly diagnosed cancer were reported in the past year. *Pica* A submitted document entitled: "Ingesting Inedible Objects" indicated the number of pica events per month. The following pica events were recorded per month, along with the type of response:	

Month	Number pica events	ER visit	Hospitalization	Procedure/surgery
February 2013	1	1	0	0
March 2013	1	1	1	1
April 2013	1	1	1	0
May 2013	1	1	1	1
June 2013	0	0	0	0
July 2013	5	4	3	1
Total = 9				

Of the nine pica events documented, one individual had five pica events and one individual had two pica events. Pica objects ingested included safety pin, paper clip, glass, latex gloves, flowers, pencil sharpener blade, and coke tabs.

Chronic constipation
One hundred sixty seven individuals had a diagnosis of constipation or received treatment for constipation

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at least weekly.

A document entitled: "Individuals diagnosed with bowel obstruction" listed the number of bowel obstructions per month:

Month	Number of bowel obstructions	Month	Number of bowel obstructions
February 2013	1	May 2013	5
March 2013	1	June 2013	1
April 2013	0	July 2013	0
Total = 8			

A separate document (untitled) listed the number of bowel obstructions over the prior year. From this information, there were a total of four bowel obstructions from February 1, 2013 through July 31, 2013. The reason for the discrepancy was not indicated. The Medical Department should collaborate with the data analyst to take corrective steps to ensure consistency of documentation and reporting.

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 through these enteral tubes (e.g., Quinolones, Sucralfate, Antacids, Bismuth, Beta blockers, Nitrates, Opioids, and Tricyclic anti-depressants). The review indicated that for three of six individuals with gastro-jejunostomy tubes or jejunostomy tubes, these medications were not prescribed. Beta-blockers were prescribed in three of six. The PCPs and pharmacists are encouraged to review the literature concerning beta-blocker administration through a jejunostomy to ensure optimal dosage, and to consider other options or monitoring if indicated.

Skin Integrity
A Skin Integrity Committee met quarterly. Minutes were submitted for two meetings in the past six months. Dates of these meetings were 4/23/13 and 7/26/13. In these meeting minutes, the number of active pressure sores was documented. It was not clear whether these numbers represented new decubiti or all decubiti being treated during the month. The data from these minutes indicated the following:

Month	Number of decubiti	Month	Number of decubiti
February 2013	3	May 2013	1
March 2013	1	June 2013	2
April 2013	0		
Total = 7			

New data was to be included in the Skin Integrity Committee meeting discussion and minutes. Included in

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		the 7/26/13 minutes were several graphs. From February 2013 through June 2013, five ulcers originated at CCSSLC. One ulcer originated outside the Facility. Six of the seven decubiti were listed with staging information. All six were Stage II. One ulcer was not listed. The data in the graphs reflected six decubiti and not seven, which was recorded earlier in the minutes. A document entitled: "Individuals diagnosed with decubitus ulcers" provided the number of new cases per month at CCSSLC: **Month** / **Number of decubiti** / **Month** / **Number of decubiti** February 2013 / 2 / May 2013 / 0 March 2013 / 1 / June 2013 / 2 April 2013 / 3 / July 2013 / 0 **Total = 8** It was noted that these two databases did not include identical information. Further review by the medical/Nursing Departments to ensure accuracy and completeness is recommended. Unfortunately, the minutes largely included data with little to no information about steps taken to prevent decubiti to the extent possible. *Weight Management* The Facility had two policies/procedures concerning weight management. These were entitled: "SSLC procedure: Weight Management," dated August 2009, and "SSLC Weight Management Guidelines – Team Roles," dated August 2009. Notation indicated that these were implemented 4/1/13. Separately submitted were a series of documents for the "Weight Management Work Group" which met 5/15/13, 6/13/13, 7/17/13, and 8/21/13. These documents included the agendas, discussion, conclusion, and action steps with responsible person, and assigned deadline. From the 8/21/13 minutes, the action item: "review the weight management guidelines team roles with the PCPs" remained ongoing. These guidelines were to be reviewed with the PCPs, with the Medical Director providing an in-service for "reviewing the weight management guidelines team roles with the PCPs." This was noted in two meeting minutes in the action items section, with the Medical Director assigned responsibility for this. However, the deadline was "ongoing," and dates of in-services were provided as evidence of closure. *Seizure management* The Facility submitted information concerning antiepileptic medication usage. One hundred twenty eight individuals were prescribed antiepileptic medication (the submitted document was not dated). Of these, 62 (48%) were prescribed one antiepileptic medication, 32 (25%) were prescribed two antiepileptic medications, 21 (16%) were prescribed three antiepileptic medications, 11 (9%) were prescribed four antiepileptic medications, and two (2%) were prescribed five antiepileptic medications.	

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		Additionally, 21 individuals with a diagnosis of seizures were on no antiepileptic medications. Eleven individuals were considered to have a refractory seizure disorder. Two of these had a Vagus Nerve Stimulator (VNS) implant. There were no individuals with a refractory seizure disorder who were currently being evaluated for a VNS. According to the submitted document entitled: "People who have been sent to the ER for uncontrolled/prolonged/new onset seizures," in the prior six months, one individual was sent to the ER for an uncontrolled/prolonged/new onset seizure. Three individuals were diagnosed with status epilepticus from February through July 2013. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 18 (14%) individuals with seizures were prescribed Dilantin, zero (0%) were prescribed Primidone, two (2%) were prescribed Phenobarbital, and zero (0%) were prescribed Felbamate. Additionally, nine individuals had a VNS implant. The Facility submitted neurology consultation notes and other active record documentation (i.e., PCP exam, medical quarterly reviews, MOSES/DISCUS results, QDRRs, lab results, seizure logs, seizure records, etc.) as evidence of seizure management for five individuals. These individuals are listed in the documents reviewed section. The following provides a summary of the review of these records, based on the contents of the entire packet submitted rather than the neurology consult note only: ▪ Five of the five (100%) individuals had been seen by a neurologist over the prior three years. Four of five had been seen over the prior two years. Three of five had been seen over the prior one year. ▪ For four of the five (80%) individuals, documentation indicated a description of the seizures. ▪ For five of the five (100%) individuals, there was documentation of frequency of seizures. ▪ For five of the five (100%) individuals, documentation included a review of current medications for seizures and dosages. ▪ For two of two (100%) individuals, there was documentation of blood levels of antiepileptic medications. ▪ For four of the five (80%) individuals, the neurology consult included recommendations. ▪ For four of the five (80%) individuals, reference in the neurology consult was made to wellness or adequacy of control of seizures. <u>Do Not Resuscitate Orders</u> A total of 21 individuals at the Facility had DNR orders in place. The date of the most recent DNR review was submitted. The 21 DNRs were reviewed from 10/8/12 through 4/29/13. For five of 21 (24%), adequate clinical justification was provided for the DNR: four individuals had a neurodegenerative disorder, and one had compromised respiratory function. Additionally, five others had a diagnosis of osteoporosis. Although chest compression might be detrimental in causing cracked ribs or flail chest, and potentially doing harm to the individual (if the individual were to survive, the chance of uncomplicated recovery would be reduced, and the post recovery process would be prolonged and painful), it is suggested that these cases be discussed at the Facility ethics committee meeting, with guidance from the State. An alternative might include providing IV medication and bagging with oxygen and withholding	

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		the chest compression aspect of CPR, which would produce further harm. For one individual, the diagnosis listed was "terminal condition," which needed further review by the Facility. Additionally, 10 other individuals with DNR status had a DNR status based on family request. The terminal condition and whether or not it was consistent with State office policy and State statutes, was not provided. The Monitoring Team disagreed with the Medical Department's finding that 100 percent of DNR orders had documentation of justification. It is recommended the Medical Department review all DNRs to ensure there is a terminal diagnosis consistent with these regulations and policies. Additionally, an individual recently hospitalized was reported to have had a DNR decision made by family members, according to a hospital liaison report dated 9/12/13. No further information was available concerning the current DNR status of the individual. The Medical Department provided a list of DNR orders for individuals without guardians. These individuals were ranked by severity of illness. Criteria included enrollment in hospice services, the number of hospitalizations in the prior two years, severity of underlying disease, and age. Those that were ranked highest had criteria indicating risk of imminent clinical decline, and would potentially benefit from the decision-making role of a guardian in the immediate future. This should provide guidance to the Facility concerning prioritizing guardianship applications and efforts. From the review of 10 medical records, two of 10 had an out-of-hospital DNR. The Facility Ethics Committee had not met since the Monitoring Team's last visit. <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-	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician audit review (Round #7). The following represents a synopsis of the information: ▪ For the one external peer review dated June 2013, 25 records were reviewed for the general medical audit and eight records were reviewed for the medical management audit. PCP compliance in essential areas of the general medical audit ranged from 84 to 100 percent. For areas considered non-essential, compliance ranged from 95 to 97 percent. ▪ The external audit review process information indicated the number of records chosen for the general medical audit was 25 records. ▪ The external audit review process information did not indicate how the sample was obtained. ▪ Essential areas that appeared to need improvement from the external peer review included answers to the following audit probe 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? (4) Is the annual physical exam and summary	Noncompliance

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	Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	current? (5) Is the annual physical summary complete including PNM, family history and a plan of care? (6) Does the summary include significant medical events of current and past years (including hospitalizations, ER visits, and outpatient surgery)? (7) Are drug and/or food allergies, intolerances, or adverse drug reactions appropriately documented? (17) Are medically appropriate diagnostic tests and/or therapeutic procedures ordered? ▪ Nonessential areas that appeared to need improvement from the external peer review included answers to the following audit probe questions: (8) Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products? If the individual uses tobacco products was there documentation for recommendation for cessation of tobacco use? (9) Have the appropriate immunizations been given? (14) Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the Quarterly Drug Regimen Review Form within 15 business days? (18) Are responses to lab values that needed interventions documented in the integrated progress notes 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? (25) Has the provider ordered appropriate consultations for identified need and diagnosis? ▪ From the external peer review audit, there were 22 corrective action plans generated. ▪ An external medical management audit for Round #7 also was completed in June 2013. The three areas of clinical focus were: osteoporosis, diabetes mellitus, and pneumonia. ▪ Areas that appeared to need improvement from the external medical management peer review audit included answers to the following audit probe questions: o Osteoporosis: (3) Is there a diagnosis of a pathological fracture? (A "No" answer appeared to be scored as poor compliance, and the question needed further review for appropriateness as an audit tool indicator of compliance). o Diabetes mellitus: (1) Is diabetes listed on the Active Problem List? (3) Did the provider order appropriate diagnostics and consults if warranted? o Pneumonia – all responses indicated compliance. ▪ From the external medical management audit for Round #7, there were five corrective action plans generated. Three of these involved Osteoporosis, concerning history of a pathological fracture. These were considered a programming error. ▪ Based on submitted documentation, the external reviewers had not provided the Facility with a summary of the review, including aggregate data representing their findings. ▪ No information was submitted to indicate whether a Medical Provider Exit Interview was conducted following completion of the audit. Submitted information documented that the external medical audit was completed according to schedule, but there was a delay in the PCPs receiving the results of the audit. ▪ There was analysis for compliance per question across the PCP clinical practices. The Medical Department was able to provide the results of the external general audit and the external medical management audit for each PCP. For the external general audit, this information was further categorized for essential and non-essential elements. ▪ There was no information provided to determine whether the most common areas of non-	

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		compliance, which might need additional focus, were identified. The above external audit review process (i.e., general medical audit and medical management audit) for Round #7 reviewed 33 record which represented 14% (33/241) of the records at the Facility. The prior external audit process reviewed 13 records. The combined review (13 + 33) equals 46 (19%) records reviewed at the Facility. This was largely consistent with the expectation that 20 percent of active records would be reviewed annually. ▪ The QA Department compiled the compliance data with corrective action plans. ▪ The QA Department tracked corrective action plan resolution at intervals. Twenty-two corrective actions were followed. Monitoring dated 9/2/13 indicated that 22 of 22 (100%) had been completed. Five corrective actions from the medical management external audit did not have tracking data submitted. It was noted that the summary chart did not include several of the individuals audited. For this report, raw data was reviewed and additional information added to ensure completeness. The Medical Department stated that these corrective action plans were completed within 30 days, but there was no confirmation through the QA Department documentation. ▪ There were no Medical Department staff meeting minutes that documented a discussion of the results of the external peer review results. ▪ There were no Medical Department 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. <u>Mortality Reviews</u> At the time of the Monitoring Team review, the Facility had no outstanding clinical death reviews for deaths that occurred more than 30 days from the Monitoring Team's visit. Since the start of the Monitoring Team's last visit, two deaths had occurred: ▪ The average age was 58. ▪ The causes of death were: respiratory failure due to pneumonia and metastatic breast cancer. ▪ An autopsy was performed in one of two. ▪ Two of two had DNR orders. ▪ Two of two had been hospitalized in the prior year. ▪ One of two had been hospitalized within four months of death. ▪ The active record included documentation indicating aggressive medical treatment until a decision of DNR was made for two of two. ▪ One of two was enrolled in hospice. ▪ One of two was considered ambulatory (either independently or with assistance). Since the Monitoring Team's last visit, two clinical death review investigations and two administrative death reviews were completed. 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 one death, an	

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		undated, untitled document (possibly September 2013) was submitted that listed six corrective action plans. Five of six had documentation of closure. Three recommendations were specific clinical recommendations concerning the individual. Three recommendations were systemic. These three concerned documentation forms to be used by direct support professionals, addressing hospice services in a timely manner, and obtaining an electronic checklist from the Hospital Liaison Nurse. This document indicated that the one outstanding action plan involved addressing hospice services in a timely manner. This undated and untitled document listed a different set of recommendations than the clinical death review committee minutes. Four recommendations were listed in the minutes. All four included changes in policy or protocol for clinical issues, which could be implemented across campus. There was follow-up documentation of these four recommendations. The Medical Director sent an email dated 6/18/13 to the clinical staff and Facility Administration concerning a change in policy for the medical staff. A memorandum, dated 9/8/13, from nursing administration addressed three of four recommendations. Rosters of in-services for these three recommendations were submitted. None were dated, but they recorded the subject of the three recommendations, and included 18 to 19 signatures of nursing staff. The reason for the difference in recommendations from the clinical death review committee and the additional submitted undated untitled document was not determined, although this untitled document appeared to refer to action steps immediately after notification of death. There did not appear to be an overlap in the recommendations. For the total of 10 recommendations, nine had been completed. There remained one outstanding. For the other death, there was one systemic documentation recommendation, which was completed. This was referenced in the ICST Meeting of 9/25/13. It was not clear if this was to be incorporated into an addendum of a current medical records or other departmental policy. Administrative death reviews included from three to four recommendations per review, for a total of seven recommendations. Recommendations were similar to those listed in the clinical death reviews. The administrative death review separated one recommendation from the clinical death review into three separate recommendations. ▪ Systemic issues related to potential improvements in medical care were one of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in nursing care were three of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in transition of care to the ER, hospital, rehabilitation or nursing home, or hospice were zero of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in pharmacy services were zero of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in dental services were zero of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in habilitation therapies were zero of the seven recommendations from the administrative death reviews.	

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		▪ Systemic issues related to potential improvements in non-medical care were zero of the seven recommendations. ▪ Systemic issues related to documentation were three of the seven recommendations from the administrative death reviews. ▪ Systemic issues related to potential improvements in other departments (e.g., maintenance, housekeeping, furlough, etc.) were zero of the seven recommendations from the administrative death reviews. ▪ The Facility submitted follow-up documentation for seven of seven administrative recommendations. The Facility demonstrated that an external medical peer review process was in place, approached the threshold of a 20% review of records annually, and had a QA system to follow up on corrective actions until closure. Separately, the PCPs were tracked. The most common clinical areas needing improvement were defined. As a continuing challenge, there have only been six diagnoses used in the medical management reviews. Expansion of this to other common conditions/clinical needs is necessary to ensure the breadth needed of a quality review. The mortality review process indicated a timely assessment of the active record, with recommendations. There were both clinical and documentation recommendations. One or more of the clinical recommendations had systemic impact when implemented. Recommendations were acted upon until closure. The mortality review process appeared to be in place. A review by other clinical disciplines with recommendations for systems improvements in specific departments or across departments would ensure the review is broadened to all clinical areas. The number of systems issues addressed and new system action steps implemented and their outcomes would be one way to measure the quality of the mortality review process to ensure the reviews provide additional opportunity to improve quality of care at CCSSLC.	
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	<u>Medical Department Internal QA System</u> The data from the March 2013 internal medical peer review was provided. The audit questions were identical to those used in the external medical peer review audit. Thirteen active records were reviewed for the general medical audit. Compliance for PCPs in essential areas ranged from 95 to 100 percent. Compliance for PCPs in non-essential areas ranged from 94 to 100 percent. For essential elements, one area that appeared to need improvement included answers to the following audit probe questions: (3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? For non-essential elements, one area that appeared to need improvement included answers to the following audit probe questions: (23) Is the provider's clinical assessments documentation organized in appropriate SOAP format (including assessment and plan)? For the internal medical peer review general medical audit, there were 10 corrective action plans identified.	Noncompliance

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	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.	An internal medical management audit was completed in March 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: seizures, UTI, and constipation. Compliance among PCPs for seizures was 83 to 100 percent, for UTI it was 100 percent, and for constipation it was 80 to 100 percent. Compliance among PCPs ranged from zero to 95 percent. Areas that appeared to need improvement included answers to the following audit probe questions: Seizures: (2) Did the PCP complete appropriate labs at least every 6 months? UTI: (1) Is Urinary Tract infection listed on the Active Problem List? Constipation: (5) Did the provider complete a physical assessment and provide further intervention for the individual who was identified as having no Bowel Movement (BM) after medical interventions? For the internal medical management peer review audit, there were three corrective action plans identified. There was information submitted concerning tracking these corrective action plans to closure. The QA Department provided follow-up documentation of the March 2013 internal peer review audit (Round #6). Ten corrective action plans were tracked. The follow-up date was recorded as 8/21/13. Eight of ten (80%) corrective action plans had been completed. Two corrective action plans remained outstanding. The data from the June 2013 internal medical peer review was provided. The internal medical peer review audit for June 2013 reviewed 25 records for the general medical audit. The audit questions were identical to those used in the external medical peer review audit. Compliance for PCPs in essential areas ranged from 92 to 98 percent. Compliance for PCPs in non-essential areas ranged from 90 to 98 percent. For essential elements, areas that appeared to need improvement included answers to the following audit probe questions: (1) Is the Active Problem List in the correct location according to the Active record Order Guideline Index? (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 Past Medical History, family history, and a plan of care? (7) Are drug and/or food allergies, intolerances or adverse drug reactions appropriately documented? For non-essential elements, areas that appeared to need improvement included answers to the following audit probe questions: (8) Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products? If the individual uses tobacco products was there documentation for recommendation for cessation of tobacco use? (9) Have the appropriate immunizations been given? (10) Are the appropriate preventive screening services provided? (11) Is there documentation present for not providing preventive services? (13) Are the current 180-day orders present in the record? (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? (21) Is each of this person's progress notes and orders signed, dated, and timed? (24) Do individual progress notes regarding acute medical problems contain pertinent positive and negative findings? (26) When a referral for consultation is requested, is pertinent current and past medical	

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		history included in communication with the consultant? (27) Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? (30) If a medical treatment was ordered during an acute illness or injury, was an assessment done within 24 hours and was it documented in the progress note? For the internal medical peer review audit, there were 26 corrective action plans identified. An internal medical management audit was completed in June 2013, utilizing the same audit questions from the external medical management peer review for the following clinical concerns: osteoporosis, diabetes mellitus, and pneumonia. Eight records were reviewed for the internal medical management audit. Compliance among PCPs was at 80 percent for osteoporosis, 80 to 100 percent for diabetes mellitus, and 30 to 42 percent for pneumonia. Per PCP, compliance across these diagnoses focused audits ranged from 30 to 90 percent. Areas that appeared to need improvement included answers to the following audit probe questions: Osteoporosis: (3) Is there a diagnosis of a pathological fracture? (Additional comments concerning this audit probe are discussed with regard to Section L.2.); Diabetes mellitus: (1) Is diabetes listed on the Active Problem List? (6) Did the provider evaluate and assess the individual for other risk factors such as smoking, hypertension, and obesity? Pneumonia: (5) Did the provider order a GI consult or a pulmonary consult if indicated? (6) Did the provider recommend a suction toothbrush for the individual or refer to Dental Clinic? (7) Did the provider refer the individual to the QDDP or the PNMT nurse after the last dx of aspiration pneumonia? (8) If the individual has a diagnosis of GERD, is it on the Active Problem List? (10) Did the provider order respiratory therapy? (11) Did the PCP review the risks and interventions for the individual for aspiration pneumonia and recommendations made? (12) Did the provider review the medications to see if any change or addition was needed to reduce the risk of aspiration pneumonia? For the internal medical management peer review audit, there were 19 corrective action plans identified. Three of these concerned the osteoporosis audit probe for pathological fractures. The Medical Department reviewed the results of the internal peer review medical management audit for each PCP. There was also identification of clinical indicators needing improvement. The two indicators having the highest rate of noncompliance were: "Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved?" from the March 2013 audit, and "Is the annual physical exam and summary current?" from the June 2013 audit. The Medical Department confirmed that the essential elements for the internal and external general medical audit did not reach 100% percent compliance. Non-essential areas did reach over 80 percent compliance. It was noted that the Medical Department's compliance for the specific diagnoses in the medical management audits for March and June 2013 appeared to reflect higher rates of compliance than the findings from the Monitoring Team's review. There was information submitted concerning tracking these corrective action plans to closure. The QA Department provided follow-up information concerning the June 2013 Internal medical peer review audit	

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		(Round #7). Twenty-five corrective action plans were identified for follow-up. The date of the follow-up review by QA was recorded as 9/2/13. At that time, 21 of 25 (84%) corrective action plans had been completed. The QA Department also submitted an additional template for the internal medical management audit follow-ups. It appeared that 28 correction actions were identified. There was considerable duplication of the corrective action plans in the submitted documents for one of the templates. When cross-referencing the documents for the internal medical management audits from March and June 2013, new names had been entered. Additionally, at least one name from the March 2013 audit had been included in the June 2013 template. The QA Department needed to further review the inconsistencies. The summary information submitted for the June 2013 audit tracking did not include all individuals for which the internal audit was conducted. Additional raw data was reviewed and added to determine the number of corrective actions and the types of audit probes needing improvement. Results of follow up corrective action plan completion should be provided in a quarterly report to the Medical Department and Facility Administration. <u>Inter-rater reliability</u> The QA Department did not provide inter-rater reliability scores for the past six months. It is recommended that data for inter-rater reliability be tracked, and analyzed, and steps be taken to improve inter-rater reliability between the external and internal medical peer review auditors. <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 the Medical Department completed medical staff meetings to discuss results. There was no evidence that medical staff meetings documented identification of areas needing improvement. There was no evidence that medical staff meetings documented development of a plan of improvement. There was no evidence that medical staff meetings documented implementation of a systemic plan of correction for the Facility. <u>Medical Department Internal Reviews/ Initiatives and Improvement Projects</u> The Medical Department had implemented additional processes for internal peer reviews. The monitoring indicator tools and results are discussed with regard to Section H.3. There were no quarterly reports summarizing internal quality initiatives. There were databases created and utilized for the clinical indicators described with regard to Section H.3. There was data analysis of the information obtained by these internal audits. Details are provided with regard to Section H.3. These analyses included charts/graphs for each of the internal reviews, which were reviewed at periodic intervals (every six months, etc.). There was no information submitted concerning follow-up of these findings from the internal Medical Department audits. As noted with regard to Section H.4, an additional component of review needs to focus on the outcome of care for the individuals (e.g., results of a caloric reduction in diet or exercise program related to weight loss goals; whether or not the iron deficiency anemia was corrected with the iron supplement; whether or not the T score stabilized on serial DEXA scans over time; whether or not the individual with congestive heart failure showed improvement in the chest x-ray, physical findings, or lab tests; whether or not the hypokalemia from a diuretic was corrected with potassium replacement, etc.).	

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		This is necessary to ensure the PCPs order the appropriate tests to monitor the clinical condition, and that there is demonstration that the individual is stable or further intervention is demonstrated, as applicable. The internal medical peer review appeared to be a mature process, with the quarterly reviews completed followed by a distribution of results by the QA Department and continued tracking of these corrective actions until closure. The medical management audits need expansion to include other significant health problems of the individuals residing at CCSSLC, such as dementia, heart failure, weight management, etc.	
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,	The Medical Department documented that there were no new finalized policies or procedures for medical screening and routine evaluations since the Monitoring Team's last visit. A policy was submitted entitled: "HCG – Medical and Nursing LL.18: Prevention – Medical and Nursing Process Criteria" with revision date of 7/16/13. There was no approval or implementation date on the document. Content focused on infection control, immunizations, medical history and physical exam screenings, Down Syndrome, preventive tests and procedures, and the diverse roles and expectations of nursing and medical staff concerning routine/maintenance/preventive health care. A policy entitled: "Employee Health Services G.01" was revised 7/16/13. The focus was on preventing, identifying, monitoring, and investigating infections among personnel and risks of infection due to employment (i.e., TB screening, vaccinations, etc.). However, the Medical Department developed a number of documents to provide guidance to the PCPs and other health professionals. These were not formal policies or procedures and had no formal dates of implementation, and focused on common medical problems at CCSSLC. These included: ▪ "Guidelines for Infirmary Observation for Fever;" ▪ "Guidelines for Evaluation of Osteoporosis and Secondary Causes of Osteoporosis," dated 7/11/13; ▪ "Guidelines for MDs on how to conduct a record review for complicated cases being admitted to the hospital or the Infirmary," dated 7/16/13; ▪ "Guidelines for using the New Section G Monitoring Tools," dated 5/31/13; ▪ "Guidelines on how to create a random sample in Excel," dated 7/15/13; ▪ "Guidelines for screening for cervical cancer with PAP smear and/or HPV testing (with flow chart for decision making)," dated June 2013; and ▪ "Competency Checklist: Performing Nasopharyngeal Suctioning" (undated) - training for RNs by respiratory therapy. On 1/24/13, an additional protocol/guideline was implemented entitled "SSLCs: Process for on-Campus and off-Campus Consultations." No official training rosters were created. For compliance to occur for this Section, a current Medical Department policy and procedure manual would need to in place, with policies approved and implemented. There should also be a mechanism of yearly	Noncompliance

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	generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	updating of the policies/procedures/ protocols on a continual basis. This manual should include the following topics: ▪ Staffing and administration - caseloads, categories of topics for CME, CPR certification, etc.; ▪ Organizational procedure and role of integrated clinical services meeting (the morning medical meeting), including tracking of closure items, ISPAs, and open record review findings ▪ 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 with tracking of corrective action plans; ▪ 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; ▪ Quarterly Medical Department report content; ▪ Role of ethics committees; and ▪ Others as indicated. No current manual was provided for review to ensure the above areas were included, as well as to ensure the policies were reviewed in the prior 365 days.	

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 Revised Monitoring Tools for Nursing and raw data; o CCSSLC's minimum staffing numbers for nursing; o CCSSLC's Infection Control Monitoring Tools data; o Time Study for Necessary Licensed Vocational Nurses (LVNs) from Chief Nurse Executive (CNE); 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 Daily Check of Emergency Cart data; o Unexplained Medication Excess/Shortages data; o Medication Administration Observation tracking and data; o Emergency Competency Checklist data; o Emergency Equipment Checklists data; o Medical records for the following individuals: Individual #311, Individual #86, Individual #315, Individual #141, Individual #12, Individual #186, Individual #167, Individual #238, Individual #376, Individual #255, Individual #275, Individual #263, Individual #307, Individual #101, Individual #299, Individual #46, Individual #187, Individual #153, Individual #329, Individual #128, Individual #21, Individual #124, Individual #71, Individual #208, Individual #47, Individual #26, Individual #221, Individual #109, Individual #74, Individual #355, Individual #122, Individual #379, Individual #101, Individual #295, Individual #244, Individual #311, Individual #137, Individual #340, Individual #21, Individual #22, Individual #183, Individual #221, Individual #335, Individual #150, Individual #348, Individual #319, Individual #274, Individual #87, Individual #34, Individual #202, Individual #99, Individual #139, Individual #256, Individual #315, Individual #10, Individual #314, Individual #139, and Individual #156; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD) converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Real Time Audit tool data for Infection Control; o CCSSLC Outbreak timelines;

	○ Infection Control Committee meeting minutes, dated 3/25/13, and 7/24/13; ○ 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: ○ Medication Variance information from Pharmacy; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 1/30/13, and 4/3/13; ○ Medication Committee meeting minutes, dated 4/3/13, 4/29/13, 5/29/13, 6/27/13, and 7/23/13; ○ Medication Administration Observation Trend data; ○ Monthly Emergency Medical Drills reports; and ○ CCSSLC Emergency Medical Drills tracking and data. ▪ **Interviews with**: ○ Michael Robinson, MSN, RN-BC, Chief Nurse Executive (CNE); ○ Colleen M. Gonzales, BSHS, Nurse Operations Officer (NOO); ○ Peggy Sue Miclan, RN, Program Compliance Nurse (PCN); ○ Della Cross, RN, Nurse Educator; ○ Kristen Middleton, RN, Nurse Educator; ○ Pamela Nichols, RN, Infection Control (IC)/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; ○ Gary Frech, MSPharm, RPh, Director of Pharmacy; ○ Brandon Riggins, Assistant Director of Programs; ○ Rachael Martinez, QIDP Coordinator; ○ Melinda Eldrige, Competency Training Department (CTD), Director; ○ Michael Gilby, Competency Training Department, Instructor; ○ Angela Roberts, Au.D., Director of Habilitation Therapies; and ○ Rosie Cortez, OTR. ▪ **Observations of**: ○ Medication Administration in the Infirmary; and ○ Use of emergency equipment at King Fish and Sea Horse.
	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, some of the Health Monitoring Tools for Nursing had been revised and/or consolidated. Although instructions were added to the tools, the Monitoring Team's review of the revised Monitoring Tools found some problematic issues that could compromise the reliability of the data generated and would result in inadequate measurement, especially regarding 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: o It was unclear why only some findings generated were reflected in the Facility's Self-Assessment. Much of the data addressing the quality of the nursing documentation was not included. Also missing were the specific criteria for compliance for the different areas audited. o 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 nursing supports and related 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. o In addition, inter-rater reliability was reported for only one of the monitoring tools, and the information provided was unclear. Based on the problematic issues the Monitoring Team found regarding the current monitoring tools' instructions 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: o Did not consistently present findings based on specific, measurable indicators. For example, as noted above, at times, it was unclear what criteria or standard had been used to determine compliance with adequate nursing services and documentation, such as a nursing protocol. Often, the data provided did not address the quality of nursing services and related documentation, but merely the completion or presence of documentation. o There was some 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. However, some of the descriptions regarding (N) did not make sense and rendered the data uninterpretable. 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. However, no supporting data was 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, including: ▪ In June 2013, the Chief Nurse Executive position was filled; ▪ In June 2013, the existing CNE moved into the Nurse Operations Officer position; ▪ In August 2013, the QA Nurse position became vacant; ▪ In August 2013, the QA Nurse position was filled; and ▪ In April 2013, a full-time RN Nurse Educator position was filled. At the time of the review, the total nursing position fill rate was 100% for the Registered (RN) positions, and 78% for the Licensed Vocational Nurse (LVN) positions. However, since the last review, the Nursing Department had experienced some staffing challenges where the fill rate had dropped to 93% in April 2013 for RNs and 72% for LVNs. Although the fill rate for RNs had increased to the current level of 100%, the LVN vacancies had continued to be problematic to fill. However, the Facility has not used any Agency Nurses for additional coverage. Some of the Facility's positive steps forward included: ▪ The reliability of the Infection Control data continued to improve as reflected in data generated from comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics. ▪ The documentation contained on the Outbreak Reports regarding outbreaks of Influenza A and Scabies that occurred since the last review was detailed. The reports included specific clinical information regarding the individuals' status and progress, as well as any treatments initiated and precautions implemented. In addition, it indicated the IC Nurses provided a number of timely in-service training sessions to staff in response to the outbreaks and followed all cases reported to resolution. ▪ The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at King Fish and Sea Horse found that all the nurses observed 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 in this area. Although the Facility had made some positive steps forward in the areas noted above, the overall continued lack of progress found regarding the 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 to the Monitoring Team 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 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: ▪ Since the last review, the fill rate for RNs was at its lowest in April 2013 at 93%, and the highest in March and June 2013 at 99%. The fill rate for LVNs was lowest also in April 2013, and highest in February, March, and July 2013 at 78%. The Facility indicated that efforts regarding recruitment included advertising on the radio and in the newspaper, conducting two Career Fairs, and increasing communication with two local nursing colleges. The Facility reported that in spite of the variability in fill rates, there were no days when that the Facility fell under minimum staffing levels as direct RNs were used to provide coverage if needed. These fluctuations are further discussed below with regard to staffing. ▪ In July 2013, the Facility indicated that a combination of questions from both the Acute Illness and Injury Audit Tool, and the Hospital Prevention Audit Tool were integrated to construct a new Hospital/Infirmary Prevention Audit Tool, in an effort to be more proactive in possibly preventing individuals from going into the hospital or Infirmary. Although the organization and presentation of data found in the Self-Assessment under Section M.1 was generally clearer than noted in past reviews, the data regarding the new Hospital/Infirmary Prevention Health Monitoring tool (HMT) from February through July 2013 could not be accurately interpreted. It was unclear to the Monitoring Team what the specific sample size was for each month since the graph contained in the Self-Assessment indicated that "N = the total number of Health Monitoring Tools due each month," rather than it representing the total number of individuals who were hospitalized or admitted to the Infirmary, and "n = the actual number audited." In addition, it appeared that data generated from all three tools were included in one graph. This resulted in inconsistencies in data being reported for some items for certain months. Also, the information provided regarding	Noncompliance

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		inter-rater reliability was unclear, since the tools had changed as well as the auditors. However, if the Facility could further clarify some of these data and data presentation issues, the future findings generated would be clinically valuable in identifying strengths and weaknesses in the care of the individuals. ▪ On a positive note, the Facility conducted a review of 100% of the Active Records from February through July 2013 to determine if information regarding male and female breast exams, menses, vital signs, and weights was present in the records. Although the data indicated that there was variability in compliance in some of these areas, the accurate identification of these problem areas could then lead to focused action plans to address these issues. The Self-Assessment indicated that the Facility began a new process in response to these data. However, no specific information was provided regarding what the new process entailed. <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. We continue to complete HMT and provide mentoring to nurses." Discussions with the Chief Nurse Executive and Nurse Operations Officer indicated that since the last review, the Facility had experienced some staffing challenges as noted from the fill rates listed above. However, although there had been some turnover in nursing positions that included the CNE, the NOO, and the Quality Assurance Nurse, the Program Compliance Nurse had continued to conduct the monitoring activities for the Nursing Department. As noted previously, although the Nursing Department had invested much effort over the past reviews in the organization and presentation of the data in the Self-Assessment for Section M, some problematic issues continued to exist regarding the format in which the data were presented, and the identification of some of the elements regarding the data, such as its reliability and the standards used for evaluation. As a result, some of the data could not be interpreted or accurately analyzed. As noted in previous reports, the Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its accurate interpretation and analysis. Since the last review, the Facility had modified, created, and added to some of the Nursing Health Monitoring Tools. The HMTs that were being used at the time of the review included: ▪ Annual Nursing Summary; ▪ Nursing Care Plan Monitoring Tool; ▪ Hospital/Infirmary Prevention Tool; ▪ Urgent Care;	

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		▪ Integrated Progress Notes (IPNs); ▪ Nursing Protocol Spot Check; ▪ Spot Check Form (Medication Observation); ▪ Emergency Equipment Competency; ▪ Emergency Cart Checklist; ▪ Case Manager Reviews; and ▪ QA Nurse Audits. The Facility had added instructions to the tools addressing nursing documentation. However, the Monitoring Team's review of these instructions found that they did not include the use of nursing protocols as the standard for assessing the quality of the nursing care provided or related documentation when determining compliance. This affected the validity and reliability of the data generated. In addition, there was no mention in the instructions regarding Nursing Care Plans that the nursing assessments/interventions found in the care plans should be in alignment with the assessments contained in the nursing protocols for specific health issues. Without this key element by which to measure the clinical quality of the nursing services and documentation, the monitoring findings will not represent an adequate and accurate review of the quality of the clinical care and treatment individuals received. <u>Staffing</u> At the time of the review, CCSSLC had a census of 241 individuals. Since the last review, CCSSLC had some changes regarding the Nursing Department and nursing positions, which included: ▪ In June 2013, the Chief Nurse Executive position was filled; ▪ In June 2013, the existing CNE moved into the NOO position; ▪ In August 2013, the QA Nurse position became vacant; ▪ In August 2013, the QA Nurse position was filled; and ▪ In April 2013, a full-time RN Nurse Educator position was filled. In addition, at the time of the review, the Nursing Department had a total of 112.1 allotted positions, including 59.7 for RNs and 52.4 for Licensed Vocational Nurses. At the time of the review, the total nursing position fill rate was 100% 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 experienced some staffing challenges where the fill rate had dropped to 93% in April 2013 for RNs and 72% for LVNs. Although the fill rate had increased to the current level of 100% for RNs, the LVN vacancies had continued to be problematic to fill. However, the Facility had not used any Agency Nurses. The CNE indicated that from a Time Study he conducted at Coral Sea regarding	

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		medication administration, he determined that the minimum staffing of four nurses on day and evening shifts should be increased to six. At the time of the review, the CNE was evaluating the need to convert five RN positions to 8.5 LVN positions to meet the needs of the individuals at CCSSLC. 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. <u>Quality Enhancement Efforts</u> In August 2013, the Quality Assurance Nurse position had experienced turnover. At the time of the review, the QA Nurse position recently had been filled. Consequently, the auditing the QA Nurse usually conducted was in the early stages of being resurrected and inter-rater reliability was being established with the Program Compliance Nurse. Unfortunately, as discussed in detail above, the Monitoring Team found problems with the Facility's data contained in the Self-Assessment for Section M.1, including, for example, a lack of inclusion of the nursing protocols in the instructions for the HMTs when assessing the quality of the nursing services and documentation. As a result, the Facility's data regarding compliance related to the provision of appropriate nursing care was unreliable. It did not result in findings that comported with the Monitoring Team's findings as discussed below in relation to the nursing assessments and documentation of individuals with acute changes in status. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Consistent with the Monitoring Team's findings from past reviews, little to no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were being used to drive the identification and implementation of the specific nursing assessments, 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, regarding individuals with acute changes in health status. A review of 10 individuals' Infirmary IPNs (i.e., Individual #181, Individual #327, Individual #239, Individual #305, Individual #159, Individual #290, Individual #340, Individual #122, Individual #356, and Individual #179) 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 alignment with the nursing protocols for none of the individuals (0%).	

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		▪ The documentation indicated 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 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 alignment with nursing protocols in none (0%) of the cases. ▪ The nurse conducted assessments at the appropriate frequency for the individual's clinical condition in alignment with the individuals' overall medical status in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in alignment with the nursing protocols addressing the specific health issue in none (0%) of the cases. ▪ The documentation indicated that all acute illness/injuries were followed through to resolution in none (0%) of the cases. Although there were some IPNs that contained an adequate nursing assessment, the lack of consistency of the nursing assessments rendered the overall care of the individuals insufficient to 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. This area should be considered a priority for the Facility due to the number of individuals with complex medical needs at CCSSLC. Prompt action is needed regarding 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. However, 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.	

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		Infection Control 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 Nurses, review of the documentation, and information gathered during the review, since the last review, additional 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 continued to generate an exceptional separate Presentation Book addressing Infection Control. It provided 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, Infection Control Logs from the residences, and the Pharmacy reports for the utilization of antibiotics, the following represented the compliance percentages of antibiotics included in all reports representing data reliability checks: 93%, 100%, 98%, 98%, 95%, and 97% from February through July 2013, respectively. These data reflected consistent compliance regarding the accuracy of the documentation contained on the Infection Control Reports the residential staff completed and the reliability of overall IC data. ▪ At the time of the review, the Facility had instituted the ImmTrac, the Texas Immunization registry offered through the Department of State Health Services. ImmTrac was a secure and confidential registry available to all Texans. It consolidated and stored immunization information electronically in one centralized system. Participation required written consent and limited access to the Registry to only those individuals who have been authorized by law. Only authorized professionals such as doctors, nurses, and public health providers could access individuals' vaccination histories. The IC Nurse reported that at the time of the review, 60% of the individuals had had consent obtained and were registered. ▪ 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 systemic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility.	

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		▪ The documentation contained on the Outbreak Reports regarding outbreaks of Influenza A and Scabies that occurred since the last review was detailed. The reports included specific clinical information regarding the individuals' status and progress, as well as any treatments initiated and precautions implemented. In addition, it indicated the IC Nurses provided a number of timely in-service training sessions to staff in response to the outbreaks and followed all cases reported to resolution. ▪ The content of the minutes of the Infection Control Committee meetings continued to improve regarding the information and issues discussed to address some of the data generated from the IC Monitoring Tools. ▪ A system had been initiated to review of individuals' complete immunization histories at the time of their ISPs, and update any needed laboratory work or immunizations, as appropriate. Although the IC Nurses made positive steps forward, a number of significant problematic areas regarding infection control continued to be in need of further attention, including: ▪ Although the Facility had initiated a system for reviewing individuals' immunization histories, the Facility did not have a formal process in place to track when the process was actually completed for an individual. 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. ▪ Regarding Infection Control Environmental Checklists, as was noted in the last report, there was no indication that the problematic issues identified on the tools had been timely and adequately addressed. In addition, these audits were not being conducted monthly as required, which inhibits any meaningful analysis to be conducted or identification of trends. It is essential to use this information in conjunction with other IC data to determine if there is a correlation between the problematic environmental issues and the Facility's rates of infections. ▪ A review was conducted of 27 individuals diagnosed with an acute infection that included either MRSA, C-Diff, or Conjunctivitis (i.e., Individual #122, Individual #379, Individual #101, Individual #295, Individual #244, Individual #311, Individual #137, Individual #340, Individual #21, Individual #22, Individual #183, Individual #221, Individual #335, Individual #150, Individual #348, Individual #319, Individual #274, Individual #87, Individual #34, Individual #202, Individual #99, Individual #139, Individual #256, Individual #315, Individual #10, Individual #314, and Individual #156). Consistent with the findings from previous reviews, of the 27 individuals, eight (30%) were found to have had Health Management Plans (HMPs) addressing the infectious issue. The	

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		individuals without an HMP addressing the infectious issue included: Individual #122, Individual #379, Individual #295, Individual #244, Individual #340, Individual #21, Individual #183, Individual #221, Individual #335, Individual #150, Individual #348, Individual #319, Individual #87, Individual #34, Individual #202, Individual #99, Individual #139, Individual #315, and Individual #314. Of the eight Nursing Care Plans 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 continued to be improvement made regarding analyzing some of the Facility's IC data, there were still a number of audit findings from monitoring data that were not being reviewed and analyzed to comprehensively assess the Facility's infection control practices. For example, although the minutes noted that the Environmental Surveys were not being conducted monthly as required, there was no mention of the findings from the ones that were completed associated with any identified infectious trends. 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. The Facility had made some positive steps forward, however, some of the consistent problematic areas such as the lack of care plans and the inadequate care plans regarding infectious illnesses need to be addressed in order for substantial gains to be made in meeting the requirements of the Settlement Agreement. As noted in previous reports, consideration should be given to providing the Facility with additional expertise and technical assistance in Infection Control to assist in effectively operationalizing the infection control systems in alignment with IC standards of practice and the Settlement 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 February through July 2013 indicated that the daily Emergency Cart checks were consistently being done ensuring that the equipment was available for all emergency situations. ▪ The Facility's review of the monthly Emergency Competency skills checklist data from February through August 2013 showed the following compliance rates:	

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		92%, 61%, 96%, 100%, 100%, and 90%, respectively. The data indicated a significant drop in March 2013. The five of the six nurses who failed the competency checks were new nurses and were not familiar with where much of the emergency equipment was located. In response to this finding, the Nurse Educators had incorporated taking new nurses to a home and reviewing the emergency equipment in the environment that they would be working in as a part of the mentoring process. Since that process was initiated, the compliance scores for this area had significantly increased. In addition, other positive steps made since the past review included: ▪ The Nursing Educators continued conducting spot checks of emergency equipment use and oxygen flow rates. The Monitoring Team's observations of nurses demonstrating the emergency equipment at King Fish and Sea Horse found that the nurses observed were familiar with the use and operations of the Facility's emergency equipment. It was clear to the Monitoring Team that the consistent drills, spot checks, and change in the new nurse mentoring process noted above regarding the emergency equipment were having a very 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 continued to implement positive steps addressing the Emergency Response System, there continued to be no clinical review of the Mock Code Drills as well as the actual medical emergencies (6333) 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 define the role of the clinical staff regarding the review of Emergency Mock Code Drills and actual medical emergencies. Since the last review, the data from the drills conducted were as follows: ▪ 17 drills conducted in February 2013 – 12 passed (71%); ▪ 17 drills conducted in March 2013 – 14 passed (82%); ▪ 17 drills conducted in April 2013 – 15 passed (88%); ▪ 19 drills conducted in May 2013 – 18 passed (95%); ▪ 17 drills conducted in June 2013 – 16 passed (94%); and ▪ 16 drills conducted in July 2013 – 16 passed (100%). Clearly, the Facility had made positive steps forward regarding CCSSLC's Emergency Response System. However, there continued to be problematic issues related to a number of the requirements in Section M.1 of the Settlement Agreement. The Facility reported that: "based on the findings from this self-assessment, this provision is not in	

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		substantial compliance. While some upward trends were 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: ▪ Based on the Facility's review of the timeliness of completion for 97% of the Quarterly and Annual Nursing Comprehensive Assessments due from February through July 2013, the data indicated that while the assessments were consistently available on the shared drive on the computer (95% to 99%), they were not consistently found filed in in the Active Record (68% to 82% compliance) within the month they were due. ▪ In addition, the Facility indicated that a review of 18 to 36 percent of the annual nursing assessments from February through July 2013 found that not all diagnoses that were rated high or medium on the Integrated Risk Rating Forms were being addressed, especially regarding dental issues ranging from 0 to 33% compliance. Also, in reviewing the Annual Comprehensive Nursing Assessments, the Facility reported low compliance scores for indicators regarding hospital admissions, Nursing Diagnoses, summaries of current treatments, effectiveness of treatments, analyses of status through a comparison from the previous year, documentation indicating if issues were better or worse, and additional recommendations implemented. However, the Facility's Self-Assessment presented no specific data addressing each of these indicators. ▪ In addition, the CNE indicated that since the last review, no interventions had been implemented to address the problematic issues found during previous reviews regarding the nursing documentation for individuals transitioning to the community. <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. We continue to self-assess and determine new systems to correct current issues. We currently have an action plan for M.2 step 4 & 5; completing monitoring tools and providing mentoring to nurses. Corrective action plans will be developed for systemic issues that are identified." Although the Facility's finding of noncompliance was consistent with the Monitoring Team's findings, 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	Noncompliance

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		overall quality of the content of the Comprehensive Nursing Assessments. At the time of the review, the CNE reported that due to the number of challenging staffing issues that affected the department since the last review, there had been a lack of overall progress in addressing this provision of the Settlement Agreement. In addition, of major concern was that thus far in the review process, CCSSLC had not yet developed a clinically appropriate competency-based curriculum addressing the quality of the documentation that should be contained in the Comprehensive Nursing Assessments. Also, due to the lack of implementation of the nursing protocols resulting in the lack of relevant nursing assessments being conducted on the individuals, there was a significant absence of clinical data generated during the past several quarters to even analyze. Consequently, the Monitoring Team continued to find the Facility's Comprehensive Nursing Assessments to be clinically inadequate. 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 #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections. ▪ Of the 22 individuals' nursing quarterly assessments reviewed, 22 (100%) were timely completed. ▪ There was an adequate analysis of the health/mental health data between the previous and current quarters in one (5%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues. The one was for Individual #86 regarding aspiration risk. ▪ There was an adequate assessment of the high and medium risk health indicators included in one (5%) of the Comprehensive Nursing Assessments. This was for Individual #86 regarding aspiration risk. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. As noted above, the Monitoring Team found that there had been little progress made regarding the quality of the quarterly/annual Comprehensive Nursing Assessments. Consistent with the findings from the previous seven reviews with the exception of one assessment, none of the other Comprehensive Nursing Assessment summaries reviewed included an adequate analysis of the individuals' health/mental health issues between	

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		quarters indicating if the health issues were improving, maintaining, or getting worse. Although CCSSLC's action plan addressing this requirement included action steps regarding training for the Case Managers regarding the new Annual and Quarterly Nursing Assessment forms and revised Integrated Risk Rating Form, no steps were found to improve the quality of the content of the nursing assessments. Interviews with nursing leadership appeared to show an increase in understanding regarding the use of the Nursing Protocols in guiding nursing assessments and the associated nursing documentation. However, the consistent lack of progress found regarding the quality of the Comprehensive Nursing Assessments continued to be very concerning due to the potential impact it had on the health and wellbeing of individuals residing at the Facility. It is essential 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. Appropriate competency-based training and mentoring regarding the Quarterly/Annual Comprehensive Nursing Assessments should be provided from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. As noted in previous reports, this area should be considered a priority for nursing. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the nursing documentation and Nursing Discharge Assessment Summary for eight individuals (i.e., Individual #71, Individual #208, Individual #47, Individual #26, Individual #221, Individual #109, Individual #74, and Individual #355) found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individual. ▪ 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 for the individual was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%). ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues for the individual in none of the eight (0%) records reviewed. Again, as noted in previous reports, it is crucial 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	

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		and detailed enough to maintain continuity of care. Based on the Monitoring Team's findings, the Facility remained in noncompliance with this provision.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	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: ▪ Although the Facility's presentation of data for Section M was very promising, the Monitoring Team could not accurately interpret the data contained in the Facility's Self-Assessment addressing this area. This was because it was unclear what was meant by "n" representing the "actual number of IHCPs," and how the sample was selected from the number of ISPs due each month (N). In addition, it was unclear what criteria were used to determine compliance for each item listed. For example, compliance scores of 86% and 100% were reported for the following items regarding the IHCPs: "has been revised, as necessary, based on the clinical needs of the individual" and "there is evidence that nursing interventions were implemented promptly after they were developed or revised" respectively. The Facility's findings were not in alignment with the findings of the Monitoring Team provided below. In addition, no data were provided to assess whether the IHCPs were in alignment with the nursing protocols for the specific health issues, which is crucial to the quality of care of the individuals. <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. We continue to self-assess and determine new systems to correct current issues. We currently have an action plan for M.3 step 2 completing monitoring tools and providing mentoring to nurses. Corrective action plans will be developed for systemic issues that are identified." The records of 22 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections Of the 22 individuals' Nursing Care Plans/Integrated Health Care Plans reviewed: ▪ All 22 (100%) were found to have a care plan addressing their high or medium	Noncompliance

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		risk health/mental indicator. ▪ None (0%) of the nursing interventions contained in the 22 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 when they should be considered for modification. ▪ None (0%) of the 22 care plans were found to be clinically adequate. There was no indication that any type of nursing assessments were 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 22 care plans contained adequate proactive interventions addressing the health indicator. ▪ None (0%) of the 22 care plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 22 care plans, 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 and exercise" could not be substantiated as being implemented. At the time of the review, the Facility continued to have a variety of formats of care plans that included Risk Action Plans, Acute Care Plans, and IHCPs, although they were in the process of transitioning to using the Integrated Health Care Plan (IHCP) format. However, it was concerning to note the lack of progress since the last review in the quality of the content of the care plans regardless of the format used. Specifically, some of the problematic issues identified in the Facility's previous care plans were found in the current IHCPs including: ▪ 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 found 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. ▪ 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	

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		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 often generic, not measurable, 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. It is imperative that the Facility address the lack of clinically adequate care plans for the individuals under their care regardless of the system and system changes made to the Facility's overall plans of care. As previously recommended, 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 infectious illness, the documentation the Facility provided to the Monitoring Team indicated there had been 27 individuals diagnosed with an acute infection that included either MRSA, C-Diff, or Conjunctivitis (i.e., Individual #122, Individual #379, Individual #101, Individual #295, Individual #244, Individual #311, Individual #137, Individual #340, Individual #21, Individual #22, Individual #183, Individual #221, Individual #335, Individual #150, Individual #348, Individual #319, Individual #274, Individual #87, Individual #34, Individual #202, Individual #99, Individual #139, Individual #256, Individual #315, Individual #10, Individual #314, and Individual #156). ▪ Of the 27 individuals, eight (30%) were found to have had Health Management Plans (HMPs) addressing the infectious issue. The individuals without an HMP addressing the infectious issue included: Individual #122, Individual #379, Individual #295, Individual #244, Individual #340, Individual #21, Individual #183, Individual #221, Individual #335, Individual #150, Individual #348, Individual #319, Individual #87, Individual #34, Individual #202, Individual #99, Individual #139, Individual #315, and Individual #314. ▪ Of the eight Nursing Care Plans reviewed, none were found to be clinically adequate (0%). At the time of this review, CCSSLC had no system in place to ensure that individuals with infectious diseases were being tracked, monitored, and provided care plans that included the appropriate infection control measures, and clinically appropriate interventions to prevent the spread of infections. Consistent with findings from previous reviews, Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the care plans addressing infectious and	

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		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, little to no progress had been made addressing this provision of the Settlement Agreement. 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 Annual Skills Lab-check off of all annual competencies; Mosby Class-review of Mosby guide to physical examination regarding the neurological system; new nursing protocol cards including Emergency/Hospital transfers, suspected fracture/dislocation, pain, fall or suspected fall, and hypoglycemia; Weight clinic; and the Mortality Review Action Plan. Although the trainings were positive steps, it was unclear to the Monitoring Team how most of the listed training classes related to this particular provision, with the exception of the training regarding nursing protocols. ▪ In addition, the Facility's Self-Assessment indicated that they had conducted a review of Integrated Progress notes (IPNs) to determine if Nursing Protocols were being used regarding Antibiotic Therapy, Fall or Suspected Fall, Respiratory Distress-Aspiration, Vomiting, and Urinary Tract Infections. Although the presentation of data found in the Self-Assessment for Section M was significantly clearer than noted in past reviews, the procedure for auditing this area that the Program Compliance Nurse (PCN) described during the review appeared to have generated unreliable findings, especially regarding nursing	Noncompliance

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		documentation and nursing protocols. As described, the criteria for initiating a nursing protocol audit was based on the occurrence of an acute event and not when there was an existing health issue requiring nursing assessments in alignment with nursing protocols. Consequently, the Facility's current audit procedure for nursing protocols reinforced reactive care rather than proactive care. Only reviewing reactive care 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. In addition, some of the sample sizes used were extremely small (N=72, n=1), while some of the data tables did not include the population (N) and those audited (n) to determine a percent sample size. Also, there were months that had no data, as well as a number of items that were reported as being at 0% compliance. Consequently, the Facility's conclusion reported in the Self-Assessment indicating that they were in compliance with the requirements of the Settlement Agreement for this areas was not supported by the data presented and 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, ongoing and adequate nursing assessments in alignment with the nursing protocols for the particular health issues the individuals were experiencing generally were not found. Unfortunately, the additional documentation in IPNs did not result in an improvement in clinical care. <u>Self-rating</u>: 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. We have implement [sic] 23 reporting protocols and have a system in place to monitor use of protocols and provide mentoring to nurses as issues are identified. We currently have an Action plan in place for M.4 steps 2 and 3 and will develop corrective action plans as systems issues are identified." As noted above, although the training classes that were provided to the nurses since the last review were positive steps, no explanation was provided in the Facility's Self-Assessment regarding how the training classes listed demonstrated that substantial compliance had been achieved with this requirement of the Settlement Agreement. Although the Presentation Book for Section M indicated that training had been provided to 100% of the nurses regarding the new statewide Protocol Cards, the data presented in the Facility's Self-Assessment did not represent or indicate that nursing assessments and reporting protocols sufficient to address the health status of the individuals served were actually being implemented as the Settlement Agreement requires. Also, no information was provided that specifically addressed how the Facility was enforcing the "implementation" component of the Settlement Agreement requirement to indicate how	

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		compliance will be achieved. Although the Facility indicated that they were in substantial compliance regarding the implementation of the nursing protocols, the Monitoring Team found little to no evidence that they actually were being used. In fact, essentially the same significant problematic issues were found during 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 the Infirmary and/or a community hospital, Section M.2 regarding nursing assessments, Section M.3 regarding the care plans, and Section M.5 related to individuals with high-risk health indicators clearly demonstrated that the Facility was not implementing the nursing protocols. Although additional training had been provided since the last review, the problematic issues related to the lack of nursing practices and care in alignment with the standards of care outlined in the nursing protocols essentially had not improved as a result of the 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 #139's health care prior to her death in April 2013 from respiratory distress. Based on the documentation the Facility provided identifying risk ratings, Individual #139 was noted to be at risk for aspiration, respiratory compromise, dental, osteoporosis, cardiac disease, gastro-intestinal, seizures, circulatory, fractures, infections, urinary tract infections, skin integrity issues, and poly-pharmacy. However, it was impossible to determine the risk ratings (high or medium) of each of the risk factors, because the IRRF found in the record was undated and the Risk Level column of the form was left blank. The IRRF included some data related to the risk ratings, but the team had not indicated the risk rating designations. In addition, the IHCP, dated 2/12/13, did not state the risk levels. The documentation did indicate that on 10/4/10, she had a G-Tube placed after she had an aspiration pneumonia diagnosis on 9/18/10, and after a bedside swallow study conducted on 9/27/10 indicated she experienced signs and symptoms of aspiration with multiple consistencies. From review of the IRRF, IHCP, and last two Comprehensive Nursing Assessments, it was unclear due to the lack of specific information if Individual #139 had any history of being seen in the Emergency Room, had any admissions to the Infirmary, or had been hospitalized in the past. In reviewing the documentation from 2/12/13 to 3/29/13 when Individual #139 was admitted to the hospital where she died on 4/17/13, a number of significant problematic issues were found regarding the care of this individual. Some of these problems included:	

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		▪ The IPNs indicated that on 2/12/13, Individual #139 was experiencing pitting edema to her legs. The physician ordered an increase in her diuretic medication, Lasix, for three days and her legs were to be elevated in attempts to decrease the edema. However, there were no nursing assessments conducted regarding the status of the edema until 2/18/13. In fact, no IPNs were found for 2/14/13, 2/15/13, 2/16/13, and 2/17/13 indicating that no nursing assessments were conducted for an individual experiencing a change of status. ▪ A review of the IPNs found no regular nursing assessments of the individual's edema that included issues such as a description of the skin, the temperature of the affected extremities, pain, positioning, presence of pulses, the measurement of the edema if pitting, assessment of intake and output, and weight gain. ▪ The IPN dated 2/21/13 indicated that the individual's weight was taken and was 142.8 pounds. However, there was no information included in the note to indicate if the current weight was an increase from the previous weight that could have been related to her edema. ▪ The IPN on 2/19/13 indicated that staff reported that the individual had "stuff in her eyes and they are really red." The nursing documentation indicated that she had "thick green matter" to both eyes and that her left eye was red with "slight edema." Vital signs were taken and the IPN indicated that this information would be "placed on the calendar for a.m." However, no subsequent IPNs were found indicating that this issue had been followed, regularly assessed, and/or resolved. In addition, no IPNs addressed appropriate infection control interventions that should have been initiated in the event that the symptoms represented a contagious illness. ▪ Although the IPN dated 2/24/13 indicated that Individual #139 was experiencing shortness of breath, increased pulse (100), increased respirations (30), increased blood pressure (143/61), and intermittent wheezing in both lungs, regular nursing assessments were not initiated for an individual clearly demonstrating changes in status. A review of the IPNs found no nursing assessments or any documentation for the following day on 2/25/13. Consequently, there was no way to determine if the individual's status was getting better or worse the day after a change of status was identified. ▪ The IPNs for 2/26/13 at 0140 indicated that the individual had developed a cough, had a pulse of 90 and blood pressure was noted as 140/78. Her oxygen saturation noted as 96% on room air and her lung sounds were clear. An RN assessment was conducted at 0150 with the plan from the SOAP note stating that the medication for nasal congestion, Dimetapp, would be given and the individual would be monitored for increased coughing or difficulty breathing. There were no other nursing assessments conducted until the physician saw the individual at 1220 and noted she had an audible wheeze, was doing some abdominal breathing indicating some respiratory distress, had an elevated blood	

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		pressure of 162/98, an increase in respirations of 30, oxygen saturations were 94 to 95%, and "doesn't appear comfortable and is anxious." In spite of this obvious change in status, the next nursing assessment was not completed until 1400. Although the nursing assessment conducted at this time indicated that there was wheezing heard in both lungs on expiration, and the individual had a nonproductive cough, no vital signs or oxygen saturation rates were documented as being assessed. This was especially troubling since these particular values had negatively changed at 1220 and should have been obtained. Thus, the lack of consistent nursing assessments resulted in missing clinical objective data for comparison to adequately monitor the individual's changes in her health status. The IPNs at 1515 noted that her oxygen saturations had dropped to 91% on room air and that she appeared to continue to use her abdominal muscles to breathe. She was sent to the hospital at 1555 via Emergency Medical Services (EMS). However, no nursing assessment was found regarding the individual's status at the time of the transfer. ▪ The IPNs dated 3/28/13 at 0915 indicated that the Respiratory Therapist (RT) reported to nursing that the individual's respirations were in the "upper 20's" and her oxygen saturation was 89%. Although the RT's note indicated that she notified the physician, no appropriate nursing assessment was conducted until 1500. ▪ The IPNs for 3/29/13 indicated that the individual was sent to the hospital at 0400. However, no nursing assessment was found regarding the individual's' status at the time of the transfer. ▪ Information contained in the IRRF (undated) and the Comprehensive Nursing Assessment, dated 1/27/13, indicated that trials using a suction tooth brush were conducted on 2/29/12, 3/1/12, 3/6/12, 3/8/12, and 5/7/12. The documentation indicated that with each trial, the individual experienced coughing, crying, and anxiety. The documentation on the IRRF noted that the individual "coughs as avoidance," and has a "defensive cough." However, there was no indication from the documentation that these coughing episodes were actually assessed to rule out aspiration for an individual who had a diagnosed dysphagia and was designated by her IDT as being at risk for aspiration. ▪ The summary section of the Comprehensive Nursing Assessment, dated 1/27/13, did not adequately address any of the high or medium health risks or changes in status that this individual had experienced during the past year. ▪ The IHCP, dated 2/12/13, 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,	

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		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. ▪ The IRRF found in the record was not dated and the risk levels were left blank for each risk factor, including choking, aspiration, respiratory compromise, dental, gastro-intestinal, constipation and bowel obstruction, cardiac disease, circulatory disease, fluid imbalance, weight, diabetes, osteoporosis, falls, fractures, infections, urinary tract infections, skin integrity, seizures, poly-pharmacy, behavioral health, and hypothermia. ▪ Since there were no nursing assessments regularly conducted, changes in status could not be quickly recognized and responded to. ▪ 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, especially since Individual #139 experienced significant edema to her lower extremities. Also, a review of an additional 10 individuals that were admitted to the hospital since the last review (i.e., Individual #181, Individual #327, Individual #239, Individual #305, Individual #159, Individual #290, Individual #340, Individual #122, Individual #356, and Individual #179) found similar problematic issues throughout the nursing documentation as those found in Individual #139'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 and achieved substantial compliance regarding this requirement. From the Monitoring Team's review, there was no indication that nursing was consistently using nursing protocols as part of a structured system to guide nursing practice and the associated documentation to ensure that: ▪ Clinical baseline data were established to quickly recognize changes in health status; ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ 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. The Facility indicated that it was in substantial compliance with this requirement. However, this was not consistent with the Monitoring Team's findings from this review.	

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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: ▪ The Facility indicated that a review of three Section I monitoring tools completed for the month of July 2013 found the following: three of three (100%) of Annual Nursing Assessments were completed within 30 days of the annual ISP date and posted in the shared drive at least 10 days prior to the ISP; two of three (67%) of the Annual Comprehensive Nursing Assessments contained an adequate assessment of the specific high-risk health indicators or provided some type of analysis of the high-risk health indicators in the Summary Section; and three of three (100%) of the Integrated Risk Rating Forms indicated that nursing staff completed the 16 health categories they are responsible for completing. However, the Self-Assessment contained no indication of how the quality of the documentation was assessed in determining compliance for this area, especially in light of the problematic findings noted below from the Monitoring Team. The discrepancy in findings between the Facility and the Monitoring Team was particularly troubling since the Monitoring Team's findings noted below indicated that essentially very little progress had been made addressing this requirement 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 nursing is performing an interdisciplinary assessment of services and supports. However, they often lack the necessary components from disciplines to appropriately risk [sic] individuals. Additionally, when they do have the information available, it is often not reflected in the documentation." 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 #311, Individual #86, and Individual #315 for aspiration risk; Individual #141, Individual #12, and Individual #186 for cardiac issues; Individual #167, Individual #238, and Individual #376 for behavior issues; Individual #255, Individual #275, Individual #263, and Individual #307 for constipation; Individual #101, Individual #299, and Individual #46 for dental issues; Individual #187 for diabetes; Individual #153, Individual #329, and Individual #128 for falls; Individual #21, and Individual #124 for infections) found that six (27%) included adequate nursing risk assessments that included individual-specific	Noncompliance

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		information that clearly justified the risk ratings assigned (i.e., Individual #315, Individual #186, Individual #238, Individual #101, Individual #299, and Individual #128). A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 22 individuals found that one of them (5%) 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 (i.e., Individual #86). 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. 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 from the current year as compared to the previous year 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, no modifications or specific procedures had been 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, and in some cases, did not even include all the high/medium health risks in the Summary Section of the Comprehensive Nursing Assessments. 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%). Although all 22 individuals (100%) were found to have a care plan addressing their high or medium health/mental risk indicator in the Active Record, none sufficiently addressed the health risk in accordance with applicable nursing protocols. ▪ Implemented a plan within fourteen days for each individual, as appropriate in none (0%) of the cases reviewed. The 22 Integrated Health Care Plans that were found in the Active Records included a date of implementation. However, 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	

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		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 and exercise, 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 IHCP/Risk Action Plans into the ISPs in 22 of the 22 cases (100%). ▪ None (0%) of the plans reviewed 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 Plans contained a heading addressing "Monitoring Frequency," the frequency was either noted generally as daily or weekly without the specific shift or day included to ensure accountability, or it was not addressed. At the time of the review, the Facility was continuing to implement the revisions that had been made to the ISP and At-Risk process. However, the significant 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 interventions contained in the Risk Action Plans, HMPs, and IHCPs still had not been addressed. 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.	
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	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 indicated that the compliance data for the	Noncompliance

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	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.	Medication Administration Observations from February through August 2013 was 99%, 99%, 95%, 94%, 93%, 96%, and 97%, respectively. The Facility's data regarding the number of Medication Administration Record (MAR) blanks for February through July 2013 indicated that there were a total of 139, 175, 236, 173, 103, and 180 MAR blanks found each month, respectively. The Facility's Self-Assessment indicated that these data were addressed at the monthly nursing meetings and that the high numbers of MAR blanks were related to nursing shortages and overtime. In addition, the Facility's data addressing unreconciled medications from February through July 2013 indicated that the number of medication shortages each month were 39, 107, 21, five, five, and two, respectively, and the number of excess medications were 117, 281, 154, 315, 340, and 556 respectively. The information contained in the Self-Assessment indicated that in response to these data, the Facility had conducted training regarding the importance of counting medications on medication refill days. The Facility reported that the counting procedure that had been previously initiated was not successful, because it was not consistently conducted. At the time of the review, the CNE indicated that the data was being analyzed to drill down regarding which homes were problematic. However, no information was provided addressing the significant discrepancies between the high compliance scores reported for the Medication Administration Observations and the high number of unreconciled medications. 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." In addition to the information that was provided in the Facility's Self-Assessment, interviews with the CNE and the Pharmacist indicated that since the last review, the Facility had initiated the following steps regarding the Facility's overall medication administration system: ▪ The Facility had provided training regarding the statewide Medication Administration Competency class to 100% of the nurses at CCSSLC. The Monitoring Team's previous review of the curriculum found it to be exceptionally comprehensive. ▪ In attempts to increase the Facility's capability to reconcile medications, the Pharmacy had decreased the number of floor stock medication available on the units, and had switched many of the oral liquid and solid medications to unit does medications. In addition, the liquid medications were now provided in unit does cups, or repackaged into oral syringes for doses smaller than five milliliters or the manufacturer's smallest package available. Also, creams and ointments were changed to unit dosages. The Facility indicated that these changes assisted	

#	Provision	Assessment of Status	Compliance
		with identifying medications up to administration, reducing medication administration time, and facilitating compliance with the physicians' orders due to the fact that each dose of medication order was now in the individual's medication bin. In addition, interviews with staff indicated that these changes made it easier to track if medications were actually given as ordered to individuals. ▪ The Facility had arranged and stocked each medication cart in a consistent manner to avoid confusion and possibly delays for the nurses when they passed medications at different residences. ▪ Although the State Office policy only required Facilities to conduct Medication Administration Observation every six months for nurses scoring 90% and above on the observations, the Nurse Educators had continued to conduct monthly spot check observations that concentrated on the essential items contained on the observation tools, as well as any problematic trends that were noted from previous medication observations. ▪ The Facility continued to use a spreadsheet to track the results of the Medication Administration Observations for each nurse on campus. ▪ The CNE had conducted a time study in response to a deficiency found by the regulatory agency regarding medications not given within the required timeframes on Coral Sea. The findings of this study indicated that for a unit that had 54 individuals to whom medications were administered via G- or J-Tube, it took 17 minutes to administer medication to one individual, thus, the CNE reported that 12 additional LVNs were needed to administer medications timely and safely. At the time of the review, the Facility had added a third medication room to the Coral Sea unit and was in the process of reviewing the reallocation of nursing positions to meet the needs of the individuals regarding medication administration. Although the steps forward discussed above included some promising 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: ▪ During the previous review, the Facility, had implemented a system to address medication reconciliation that included medication counts between shifts to timely identify excess or shortages of medications Facility-wide. At that time, the Facility reported that since the procedure was initially implemented, the number of unknown excess medications had significantly decreased. Discussions with the CNE and NOO during the current review indicated that in May 2013, this process had been stopped, because nursing staff were not consistently completing it. Although the Facility had implemented other costly	

#	Provision	Assessment of Status	Compliance
		strategies, such as switching many stock medications to unit doses, to be able to better track if medications were given as ordered, it was very concerning to the Monitoring Team that the underlying problem associated with the high number of unreconciled medications as reported from interviews with Pharmacy and Nursing while onsite reflected that nursing was not administering medications appropriately as required, since issues such as order changes, refusals, and furloughs had been identified regarding the excess reconciled medications. ▪ As noted in previous reports, the Facility's data continued to indicate that the percent compliance from the Medication Administration Observations conducted remained consistently high: between 94% and 99%. However given that the Facility's data showed that 1,763 unexplained medications were returned to the Pharmacy from February through July 2013, the high compliance scores regarding the Medication Administration Observation data continued to be highly suspect. At the time of the review, there was no indication that nursing was analyzing these obvious discrepancies between data and practice. ▪ Although at the time of the review, the Pharmacy and Nursing Departments had been focusing significant energy on systems related to the number of unexplained medications that were being returned to the Pharmacy each month, the Facility provided no indication that formal focused efforts had been made to determine if these unexplained excess medications had any impact on 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 had implemented having the Clinical Pharmacist attend the morning provider meetings, there was no formal review being conducted on the type of medications being returned to the pharmacy and any clinical impact it might be having on the individuals. ▪ Although the Facility was spending much time reconciling the number of unexplained returned medications each month, the number of actual medication variances consisting of medication given to the wrong person, at the wrong time, in the wrong dose, through the wrong route, or the wrong medication was given, suggested that CCSSLC continued to have a significant problem regarding the under-reporting of medication variances. ▪ As noted above, the Facility's data indicated that there continued to be a significant number of MAR blanks from February through July 2013. A review of the medication variances (Category A-E) the Facility reported indicated the following (variance data included unreconciled excess and shortages): ▪ February 2013 – 115 variances; ▪ March 2013 – 410 variances;	

#	Provision	Assessment of Status	Compliance
		▪ April 2013 - 199 variances ▪ May 2013 – 336 variances; ▪ June 2013 – 357 variances; and ▪ July 2013 – 577 variances. Based on observations of medication administration at the Infirmary, the following problematic issues were found. Specifically: ▪ Although the nurse read the PNMP to the individual before administering the medications, lung sounds were not assessed for an individual who was at high risk for aspiration and recently had been hospitalized for aspiration pneumonia; ▪ The nurse reported that the individual was experiencing pain, but did not conduct any type of pain assessment or take vital signs before administering the pain medication, Morphine; ▪ The nurse did not know why the individual prescribed pain medications was receiving hospice care; ▪ The nurse did not check the individual's position in the wheelchair to note that the seat belt was not fastened; and ▪ The nurse did not assess lung sounds appropriately when an individual began to cough during administration of medications. A number of problematic issues continued to be noted regarding the medication administration systems at CCSSLC. 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. As recommended in previous reports, 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 of noncompliance in its Self-Assessment was consistent with the Monitoring Team's finding.	

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 Any policies, procedures and/or other documents addressing the provision of pharmacy services, including for updated policies, highlights of the approved changes; o Any pharmacy surveys completed since the last Monitoring Team visit: plans of correction and/or internal auditing procedures and reports related to pharmacy services; o List of staff who work in the Pharmacy Department, including names, titles, and degrees; o All Drug Utilization Evaluations (DUE) reports completed since last monitoring 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 polypharmacy 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 whether calendar based on 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; o For Quarterly Drug Regimen Reviews, two most recent per residential home 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 polypharmacy justification, document (with date) in which rationale was discussed for polypharmacy for psychotropic and non-psychotropic polypharmacy including those for: Individual #215, Individual #17, Individual #273, Individual #97, Individual #89, Individual #40, Individual #8, Individual #318, Individual #98, Individual #27, Individual #153, Individual #254, Individual #28, Individual #376, Individual #198, Individual #354, Individual #269, Individual #234, Individual #331, Individual #136, Individual #329, Individual #338, Individual #72, and Individual #141; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders, including those for: Individual #147, Individual #17, Individual #4, Individual #9, Individual #3, Individual #153, Individual #376, Individual #333, Individual #354, and Individual #136; o For 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #273,

	Individual #106, Individual #43, Individual #174, Individual #326, Individual #158, Individual #94, Individual #201, Individual #338, and Individual #247; o All "single patient intervention reports" in WORx system for the 60 days prior to the Monitoring Team visit; o Since the last review, 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 "notes extracts" associated with "single patient intervention reports" for the 60 days prior to the Monitoring Team visit; o For the past six months, any adverse drug reaction reports (ADR) completed; o Any 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 prior 12 months by error type, nurse, home, 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 (i.e., 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 building; o Medication history for individuals with J or G/J tubes (not G tubes); o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit; o All documentation for each emergency chemical restraint, including restraint checklist. Information for the following individuals was submitted: Individual #238, Individual #169, Individual #119 (4/16/13 1508hr), Individual #119 (4/16/13 1230hr), Individual #275, Individual #144 (3/15/13 1122hr), Individual #144 (1240hr), Individual #40, Individual #348, Individual #7 (7/1/13 1700hr), and Individual #7 (7/2/13 2045hr); o Any trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on 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 10 orders involving drug-drug interactions, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following 10 individuals: none submitted;

	o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: none submitted; o For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: none submitted; o For five new orders in which labs were reviewed/monitored, copies of serial computer screen shots for each step. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: none submitted; o For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step, including any written documentation/ information provided to the PCP and response of the PCP. For each new order, the following documents were requested: copy of new order, copy of patient intervention report documenting concern, communication to PCP, and documenting response by PCP, copy of change in new order by PCP (if applicable), and snapshot verifying change in order received by pharmacy, or copy of pharmacy label indicating pharmacy processing of change of order. If documents were not available, this was indicated. Submitted documents were for the following individuals: none submitted; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the sample size, clarification how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process: list of databases utilized (other than audit information), including title of each database/chart/table with date range of each database. When the data was collected, periodically rather than continuously, the frequency of data collection was requested; o Presentation Book for Section N; o QA follow up of pharmacy CAPs to closure;

	○ Current staffing in pharmacy as of 9/30/13; ○ Number of doses dispensed by pharmacy per month (Feb-Aug 2013); and ○ List of steps taken by pharmacy to reduce medication variances since last Monitoring Team visit. ▪ **Interviews with**: ○ Gary Frech, RPh, Pharmacy Director. ▪ **Observations of**: ○ Pharmacy and Therapeutics Committee meeting, on 10/1/13.
	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: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: Monitoring tool for new order review, QDRR assessment monitoring tools for N.2, N.3 and N.4, and QDRR laboratory audits. ○ 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 and review of pharmacy data. ○ 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 size(s) were adequate to consider them representative samples. ○ Information was not submitted to determine whether the monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. ○ The following staff/positions were responsible for completing the audit tools: Pharmacist. ○ The staff responsible for conducting the audits/monitoring had clinical experience in the relevant area(s). The Facility did not have processes in place to ensure that staff that completed monitoring were competent as monitors. ○ 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 to show whether or not the intended outcomes of the Settlement Agreement were being reached, such as the Avatar database for chemical restraints, lab data, and adverse drug reaction reports, chemical restraint trend reports, drug regimen review database, medication variance database, and WORx orders database. The quality of the data maintained in the databases was generally noted to be complete, but appeared to be inaccurate at times in regards to the medication variances. Examples of data sources that were not considered included tracking medication variances from the Medical Department and Dental Department.

	▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with all sub-sections of Section N. This was not consistent with the Monitoring Team's findings. ▪ The Facility data identified some areas of need/improvement, especially in creating new monitoring systems/programs to reduce medication variances. For those areas of need, the Facility Self-Assessment provided an analysis of the information, although the data at times was not consistent across reports. For other areas, such as unexplained excess returns, the large number continued to be a challenge in determining cause.
	Summary of Monitor's Assessment: The Pharmacy Department developed rigorous internal audits for many areas of pharmacy services, including new order reviews, and Quarterly Drug Regimen Reviews content. Many aspects of the QDRRs were well done, including the anticholinergic section in addressing risks versus benefits. There had been numerous initiatives to assist in reducing the medication variances at CCSSLC. However, numerous challenges remained. Perhaps one of the more significant concerns was the number of vacancies in the Pharmacy Department. There was only one full-time pharmacist and one part-time contract pharmacist, along with the pharmacy technicians, to complete numerous administrative and system duties, along with ensuring appropriate dispensing and accountability of medication. The Facility needs to urgently provide assistance in filling the existing vacancies with quality pharmacy personnel. Many of the findings indicated gaps, such as lack of the quarterly Pharmacy and Therapeutics Committee meeting in July, lack of completion of the Drug Utilization Evaluations, lack of timely reporting of Adverse Drug Reactions to the P&T Committee, delays in reporting ADRs to the pharmacy, and incompleteness of the single patient intervention notes in WORx. Medication variances remained numerous, and Pharmacy Department will need to develop further system approaches to determine the source of these medication variances to reduce the volume of errors. The Pharmacy Department lost its substantial compliance rating for Section N.7. At the time of this review, CCSSLC was found to be in substantial compliance with Sections N.2 and N.5, but out of compliance with all remaining subsections of Section N.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full	The Pharmacy Department staffing included the following: Pharmacy Director (RPh, MBA), one part-time contract pharmacist, three certified pharmacy technicians, and one pharmacy technician in training. There were two vacant positions, including a Quality Control Pharmacist and a Clinical	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>Pharmacist. This indicated the urgent need for further staff in the Pharmacy Department.

As noted below, the Facility did not submit the documentation requested for this section. As a result, the Monitoring Team requested and used alternative information to conduct a review.

"Patient intervention" entries for new orders entered into the WORx software program were submitted for review. The following lists the number of patient intervention entries generated per month:
<table>
<tr><th>Month</th><th>Number of single patient intervention reports</th><th>Month</th><th>Number of single patient intervention reports</th></tr>
<tr><td>February 2013</td><td>21</td><td>June 2013</td><td>3</td></tr>
<tr><td>March 2013</td><td>12</td><td>July 2013</td><td>22</td></tr>
<tr><td>April 2013</td><td>17</td><td>August 2013</td><td>23</td></tr>
<tr><td>May 2013</td><td>4</td><td></td><td></td></tr>
<tr><td>Total = 102</td><td></td><td></td><td></td></tr>
</table>
Based on review of the 102 "single patient intervention reports," 62 of 102 (61%) included the adequate minimum information (i.e., medication, dosage, duration, etc.) to document the pharmacy review and communication with the PCP. This information indicated the need for improvement in content of the "single patient intervention reports."

To determine the quality of the most recent two months of "single patient intervention reports," the quality content of the "single patient intervention report" was reviewed for the two most recent months submitted.
<table>
<tr><th>Month</th><th>Number of patient intervention reports</th><th>Partial information omitted in report</th><th>No information in report</th><th>Complete entry/total reports for month</th><th>Percentage compliance</th></tr>
<tr><td>July 2013</td><td>22</td><td>6</td><td>11</td><td>5/22</td><td>23%</td></tr>
<tr><td>August 2013</td><td>23</td><td>1</td><td>4</td><td>18/23</td><td>78%</td></tr>
</table>
Interventions were broken down into several different categories. The following categories were utilized in the new order process in describing the type of intervention based on the new order review: discontinue medication, interaction/compatibility intervention, lab monitoring, order clarification/confirmation, side effects, therapeutic consultation, allergy/disease state contraindication, change in dosage form, discontinue medication, dose change, duplicate/unnecessary therapy, and duration/frequency. Not all orders were categorized.</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>A sample of new prescriptions was not submitted for review of drug-drug interactions.
A sample of new prescriptions was not submitted for review of potential allergic reactions.
A sample of new prescriptions was not submitted for review of significant side effects.
A sample of new prescriptions was not submitted for review of lab monitoring,
A sample of new prescriptions was not submitted for review of dosage adjustments.

The Pharmacy Director indicated that there were no instances of concerns for these areas. Given that there were 126,580 to 138,794 doses administered per month, issues such as drug-drug interactions, potential allergic reactions, significant side effects, lab monitoring, and dosage adjustments would be expected. In addition, it appeared many of the components of this section had been monitored monthly by the Pharmacy Department, so it was unclear why requested documentation was not provided to the Monitoring Team. The Pharmacy needs to create a system to demonstrate these activities are being completed. At the time of the review, the Facility was not in compliance with this provision.</td><td></td></tr>
<tr><td>N2</td><td>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.</td><td><u>QDRR calendar due dates</u>
A calendar of due dates for QDRRs was submitted for the entire campus at CCSSLC. There were five quarters of due dates listed for each individual, approximately 90 days apart. Separately, a tracking log of completed QDRRs compared to due dates was submitted. From this, the timeliness of QDRRs from the most recent months of April 2013 through July 2013. For timely completion, the agreed upon time period was based upon a due date of 90 days after the prior QDRR, with additional parameters established as a time period of seven days prior to the due date through 13 days after the due date. Based on this criteria the following timeliness per month was determined:

<table>
<tr><th>Month</th><th>Total Number QDRRs</th><th>Number completed timely</th><th>Number not completed timely</th><th>Percent completed timely</th></tr>
<tr><td>April 2013</td><td>76</td><td>75</td><td>1</td><td>99%</td></tr>
<tr><td>May 2013</td><td>84</td><td>73</td><td>11</td><td>87%</td></tr>
<tr><td>June 2013</td><td>86</td><td>84</td><td>2</td><td>98%</td></tr>
<tr><td>July 2013</td><td>80</td><td>78</td><td>2</td><td>98%</td></tr>
<tr><td>Total</td><td>326</td><td>310</td><td>16</td><td>95%</td></tr>
</table>

A sample of QDRRs for 24 individuals was submitted for review, but due to a lack of dates on the QDRRs and a non-alphabetized list of individuals, it was difficult to confirm their timely completion. However, based on the review above and confirmation of timeliness for a subset of the 24 QDRRs, the Facility had continued to complete timely reviews.

The following summarizes additional results of this review:
▪ Laboratory information was submitted as part of 24 (100%) QDRRs.</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		▪ The lab results included exact values or documentation of normal range for indicated labs such as Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin A1C (Hgb A1C), lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic drug levels with therapeutic ranges). ▪ For 24 QDRRs, 24 (100%) included the date the lab was drawn. ▪ Abnormal values were identified under the notes/comments section line for that particular lab in 19 of 24 QDRRs. ▪ The lab testing that was completed, and the frequency with which laboratory testing was completed indicated that the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. Entries concerning DEXA scan results were difficult to interpret as the symbols used in recording the values was unclear (i.e., the use of the notations FTL, FTR and <>). Based on this review, the Facility remained in substantial compliance.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine	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, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for 11 chemical restraints used from February 14, 2013 to July 2, 2013. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that eight individuals had 11 chemical restraints during this time period. For the 11 chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the 11 chemical restraint forms, 11 (100%) forms included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in zero out of the 11 (0%) chemical restraint forms completed. ▪ Side effects/adverse effects and/or drug/drug interactions were noted in 11 (100%) of the completed chemical restraint forms. ▪ There was one statement that was considered a recommendation. ▪ The range of time for completion of the forms from the date of the chemical restraint was from one to 16 days.	Noncompliance

#	Provision	Assessment of Status	Compliance
	risks associated with the use of new generation antipsychotic medications.	It was noted that for three of the individuals, the chemical restraint entry was confusing. Examples of inaccurate entries for chemical restraints included "Zyprexa 10 mg 25mg 10mg IM," "Benadryl po 25mg IM," and "Ativan IM 1mg PO." Although the correct dose was mentioned in the first two examples in the pharmacy section, this was not corrected in the document. In the third example, no medication was listed in the pharmacy section, and the error on the form was not corrected. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form. Review of these documents showed: ▪ Of the 11 completed, there were 11 (100%) forms on which the psychiatry comment section was completed. ▪ For zero (0%) of the chemical restraints used, was there a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For 11 of 11 (100%), clinical justification was documented. ▪ Side effects/adverse reactions and or drug/drug interactions were mentioned in 11 (100%) of the reviews. ▪ Effectiveness was documented in zero (0%) of the cases. ▪ There were four recommendations documented. ▪ The range of time for completion of the forms from the date of the chemical restraint was from one to seven days. Separately, a submitted document entitled "Restraint Entries - Audit Report by individual: between 2/1/2013 and 7/31/13 for Crisis/Chemical" listed 11 chemical restraints for crisis intervention during this time period. The 11 chemical restraints were given to eight individuals. From this chart, two chemical restraints were given in February 2013, four in March 2013, three in April 2013, zero in May 2013, zero in June 2013, and two in July 2013. From a graph entitled "Crisis Intervention Restraints – All restraint types – Rolling 12 months comparison," the number of restraints per month did not agree with those listed in the document from the prior paragraph. This information indicated there were three chemical restraints in February 2013, two in March 2013, one in April 2013, zero in May 2013, zero in June 2013, and two in July 2013. The reason for the discrepancy was not indicated. <u>Polypharmacy</u> Of the 24 QDRRs reviewed, polypharmacy was noted in 11 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 11 of 11 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in 10 of 11 (91%). Clinical justification was provided through reference to documents with supportive evidence, such as neurology consults, psychiatric polypharmacy committee minutes, etc. ▪ Potential interactions with other drugs or food/side effect risk was reviewed in 10 of 11	

#	Provision	Assessment of Status	Compliance
		(91%) ▪ For zero of 11 (0%), the QDRRs reviewed whether monitoring/evaluation had occurred of effectiveness of the drug regimen. Polypharmacy also was reviewed through a psychotropic polypharmacy committee/review. From the 8/30/13 review, there were 10 individuals considered to have active polypharmacy, 34 individuals with stable polypharmacy, and four new admissions with polypharmacy. This is discussed in further detail with regard to Section J. <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 (100%) QDRRs indicated whether side effects/adverse risks, or drug-drug interactions were present. <u>Anticholinergic Monitoring</u> Of the 24 QDRRs, 24 (100%) were screened for medications associated with potential significant anticholinergic side effects. Fifteen QDRRs identified medications with significant anticholinergic side effects. The results of the review of the QDRRs are as follows: ▪ The anticholinergic section of the QDRR was completed in 15 of 15 (100%) of cases with this medication prescribed; ▪ Fifteen of 15 (100%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect - the clinical burden of the side effects was less than the benefit. ▪ Fifteen of 15 (100%) QDRRs listed/addressed side effects/significant risks and or drug/drug interactions <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 24 QDRRs reviewed, 12 listed atypical antipsychotic medication. Of these, 12 (100%) included lab values that reviewed endocrine and metabolic risks (i.e., BMP, glucose level, Hgb A1C, and/or lipid panel as appropriate). The QDRRs included much valuable information, and the Facility continued to make progress in this area. However, the Facility remained out of compliance due to the lack of some necessary information in the reviews conducted after the use of chemical restraint, as well as on the QDRRs in relationship to the effectiveness of polypharmacy.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18	Review of 24 QDRRs showed the following: ▪ Of the 24, 24 QDRRs (100%) had the PCP signature. ▪ Of the 24, 20 (83%) had the date the PCP reviewed the document. ▪ There were 26 recommendations (action steps to be considered or that no action step was	Noncompliance

#	Provision	Assessment of Status	Compliance
	months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	needed) from the 24 QDRRs. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 21 out of 24 QDRRs (88%). o Agreement was documented in 18 out of 24. o There was disagreement by the PCP for one QDRR. Additionally, there were two QDRRs in which one recommendation was agreed upon and one recommendation was not agreed upon. For the three recommendations for which there was disagreement, three of three (100%) included a note of justification/plan on the QDRR. o For three of 24 QDRRs, the PCP did not submit a response of agreement or disagreement o The PCP documented review within 14 days of the QDRR being completed by pharmacy in 24 of 24 (100%) QDRRs. The range of time was one to eight days. ▪ A psychiatrist reviewed 15 of 24 QDRRs. o There were six QDRRs for which recommendations applied to psychiatry. Agreement was documented in four of six. o Disagreement with justification and plan was documented in zero out of six. o No response concerning agreement or disagreement was documented for two of six recommendations. For one QDRR, there was a notation "will monitor," but no indication whether the psychiatrist's notation was in response to agreement or disagreement with the recommendations. As a result, the necessary review and documentation was found in four of six (67%). o The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in 15 of 15 (100%) QDRRs. There was a systems change made to the completion process of the QDRR reviews by the health professionals. The QDRR was to be routed in the following order: PCP, psychiatrist, and then pharmacist. This allowed monitoring of the responses by the prescribers. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 recommendations from QDRRs for which physician orders were written based on the recommendation. These are listed above in the documents reviewed section. For nine of 10, a copy of the order was included. For one additional recommendation, the comment of agreement and the comment "ordered" by the PCP was written on the QDRR next to the recommendation. In the sample of 10, 10 (100%) demonstrated that the PCP/psychiatrist acted upon the recommendation. The Facility submitted 10 recommendations from QDRRs for which the physicians did not agree with the recommendation. These examples are listed in the documents reviewed section. In 10 of 10 (100%) cases, the response with plan and or rationale was written on the QDRR.	

#	Provision	Assessment of Status	Compliance
		The Facility remained in noncompliance with this provision. The Facility had put a system in place that hopefully will correct the issues with prescribers' review and documentation of review of the QDRRs.	
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 DISCUS, and the monitoring of more general systemic side effects related to psychotropic medication with the MOSES 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. The review of the sample of the records of 17 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 was present for all of the individuals in this sample (100%). The Facility performed the MOSES evaluations every three months, rather than six months, so that this evaluation would coincide with the DISCUS. The Facility's rationale for doing this was that linking the two together would simplify the process and, thus, increase the completion rate. This was not, however, a requirement for substantial compliance. The records of the 17 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 16 of the 17 (94%) individuals. The one individual for whom documentation of the review by the prescriber was inadequate was Individual #118, because the second (signature page) from the 7/8/13 MOSES evaluation was missing for this individual. Thus, there was insufficient documentation to confirm that the MOSES evaluation was reviewed in a timely manner. 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 the 17 individuals in the sample indicated that only 15 of these individuals were prescribed antipsychotic agents that would require monitoring with the DISCUS. The two individuals who were not prescribed antipsychotic medication that would require monitoring with the DISCUS were Individual #183 and Individual #202. The documentation contained in the records of the remaining 15 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 evaluation and whether or not	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		additional action was required. Each Quarterly Review contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES were 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 psychiatric medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan, as well as an 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 10/1/13, ten individuals receiving Reglan were not also prescribed medication for a psychiatric disorder. The following sample of four (40%) individuals who fit the above criteria was selected, and included: Individual #43, Individual #270, Individual #266, and Individual #189. 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 all (100%) of the individuals in this sample. All (100%) of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner. 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 all of the four (100%) individuals. The documentation indicated that the prescribing physician had reviewed all (100%) of these evaluations in a timely manner. In reviewing this documentation, it became evident that there were periods of time during which both the MOSES and DISCUS had been performed monthly, and, in general, the frequency of the reviews exceeded the requirements set forth in the Settlement Agreement. During the onsite review, a member of the Monitoring Team also inquired about the degree of training the Residential 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 a 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 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 the nurses conducted after viewing the videotapes to illustrate they were able to utilize the correct methods for performing the evaluations. The	

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<tr><td></td><td></td><td>content of the training materials, the documentation of attendance, and the production of the testing materials/results indicated that the Residential Nurses were receiving adequate training to competently complete the DISCUS evaluations for those individuals prescribed Reglan.

The MOSES evaluation material included 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 was completed as required and reviewed in a timely manner for 100 percent of the individuals prescribed antipsychotic medication contained in the sample of 15 individuals, as well as the four individuals in the Reglan sample. In addition, the MOSES had been completed in a timely manner for all of the 17 individuals in the sample who were prescribed psychotropic medication, as well as the four individuals prescribed Reglan. All evaluations had been reviewed in a timely manner, with the exception of one evaluation for one individual in the general sample, for whom the second (signature page) was missing.</td><td></td></tr>
<tr><td>N6</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.</td><td>The Facility continued to train staff on the curriculum for “Observing and Reporting Clinical Indicators of Health Status,” which included information concerning drug reaction signs and symptoms. Although the submitted information did not indicate employee status, these appeared to be new employee rosters. The following training indicates the number of staff that completed training per month, including the department of the staff trained:

<table>
<tr><th>Department</th><th>February</th><th>March</th><th>April</th><th>May</th><th>June</th></tr>
<tr><td>Residential</td><td>10</td><td>17</td><td>19</td><td>19</td><td>26</td></tr>
<tr><td>Food Service</td><td>2</td><td>0</td><td>0</td><td>3</td><td>2</td></tr>
<tr><td>Bond Homes</td><td>2</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Security</td><td>0</td><td>2</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Psychology</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>QIDP</td><td>0</td><td>0</td><td>2</td><td>0</td><td>1</td></tr>
<tr><td>Nursing</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Physician Services</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Habilitation Therapy</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Total</td><td>14</td><td>20</td><td>23</td><td>23</td><td>30</td></tr>
</table>

No evidence was submitted indicating annual refresher training for staff had occurred. The Facility indicated there were reasons beyond the control of the Pharmacy Department for not completing the training in this clinical area.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		The following table represents data extracted from the ADR reports submitted:	

Date	Medication	Reaction	Date notified pharmacy	Naranjo ADR problem scale	ADR by evidence	Added to allergy profile/drug alert
4/7/13	Vancomycin and Zosyn	Rash	4/8/13	5	Y	No documentation submitted
4/11/13	Terbinafine	Liver function abnormal	8/14/13	4	N	N
6/14/13	Vancomycin	Kidney function abnormal	6/14/13	5	Y	No documentation submitted
5/28/13	Rocephin	Rash	8/14/13	7	Y	Y
6/13/13	Zosyn	Rash/swelling	6/14/13	4	Y	Y
6/28/13	Lopressor	Bronchospasm	8/14/13	2	Y	Not an allergy
7/2/13	Zosyn	Rash	7/2/13	4	Y	Y

At the time of the submitted documents, the ADRs were in draft form awaiting review by the P&T Committee. However, at the P&T Committee meeting on 10/1/13, these reports were not on the agenda, and the meeting a Monitoring Team member observed did not include a discussion of these reports. Additionally, it was noted that for three of the reports (i.e., Terbinafine, Rocephin, and Lopressor), there appeared to be a delay from the time of the adverse drug reaction and notification of the pharmacy. Reason for the delay was not documented on the forms provided. There appeared to be no system to ensure that future delays in reporting did not occur. Additionally, four of these adverse drug reports appeared ready to present to a P&T Committee in July 2013, but there was no committee meeting during that month or quarter. The reason for lack of meeting in a timely manner was not provided.

Since the Monitoring Team's last visit, there had been no P&T Committee meeting. The date of the last meeting was 4/3/13. At that time, no adverse drug reactions had been reported from January through March 2013. A subcommittee had been created to address the lack of reporting. The minutes from the subcommittee were not submitted to the Monitoring Team during the current site review, but the above number of potential adverse drug reactions indicated that the system had identified the concern with lack of reporting and taken some action to correct it, leading to generation of reports.

The Facility remained in noncompliance with this provision. In addition to ensuring annual

#	Provision	Assessment of Status	Compliance
		refresher training for staff, the P&T Committee needs to timely review and respond to potential ADRs.	
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.	A draft "DUE calendar" was submitted for the calendar year 2013 that documented the medications to be included in drug utilization reviews. These included: 1st Quarter 2013 (January 2013) - Vitamin D, and usage review of Lactinex; 2nd Quarter 2013 (June 2013) - GERD treatment guideline review; 3rd Quarter 2013 (August 2013) – anticholinergic use; and 4th Quarter 2013 (November 2013) – antibiotic use for UTIs. The April 2013 P&T Committee identified a presentation schedule for 2013 that was somewhat different: Vitamin D in January 2013, Lactinex in January 2013, Depakote dosage forms in February 2013, Trazodone in May 2013, Dificid (Fidaxacin) in June 2013, and antibiotic usage in UTIs in August 2013. It appeared the schedule had changed. To determine what was completed, the April 2013 P&T Committee meeting minutes were reviewed. At this meeting, documents were provided for review of DUEs and any follow-ups to DUEs: ▪ Follow-up of proton pump inhibitor use (for the GERD treatment guideline review) with data for 3/11/12 and 3/11/13, but no narrative indicating analysis, conclusion, and action plans. ▪ Follow-up of Depakote sprinkle capsule use per feeding tube (report dated 4/3/13), indicating usage patterns per building. This was an ongoing follow-up since October 2012. ▪ Incomplete DUE from January 2013: Lactinex versus Florastor versus Biogaia (undated) with a comparison chart of these three pharmacy options. There was no narrative, no review of number of individuals on each medication, etc. A separate folder indicated that a review had been completed for those taking Vitamin D supplements along with the current Vitamin D blood levels of the individuals as of 2012. This had been completed in January 2013. In June 2013, the Clinical Pharmacist provided an in-service to the PCPs, Chief Nurse Executive (CNE), and Medical Compliance Nurse concerning the professional guidelines (2011 Institutes of Medicine for Vitamin D and 2013 American College of Gastroenterology for GERD). Nine staff attended. The prior information on the proton pump inhibitor use from the April P&T Committee meeting was reviewed, along with the findings of Vitamin D usage at CCSSLC during 2012. From the submitted information, it was difficult to determine the outcome of this in-service and whether the PCPs were instructed to make changes as applicable in orders for proton pump inhibitors and Vitamin D, and whether a timeline was established for follow-up monitoring to determine impact of the in-service. The Pharmacy Department indicated the Vitamin D DUE was the only DUE completed in the prior six months. From the calendar submitted for DUEs, the DUEs that remained outstanding included 3rd Quarter	Noncompliance

#	Provision	Assessment of Status	Compliance
		2013 (August 2013) – anticholinergic use; and 4th Quarter 2013 (November 2013) – antibiotic use for UTIs. From the April 2013 P&T Committee, the schedule of DUEs that remained incomplete and/or unreported to the P&T Committee included Trazodone (May 2013), Dificid (June 2013), and antibiotic usage in UTIs (August 2013). Based on two calendars that did not agree, determining the due dates of DUEs was confusing. It appeared there had been some changes made, such as removal of Trazodone and Dificid from the April 2013 P&T Committee information, changing the time frame for review of antibiotic usage for UTIs, and adding anticholinergic use. The calendar indicated that the DUE for anticholinergic use was overdue and would have been presented at the October 2013 P&T Committee meeting. A document entitled "Antibiotic Urinary Prophylaxis (April 1, 2013 through September 30, 2013)" was submitted to the October 1, 2013 P&T Committee meeting. It listed antibiotic treatment for five individuals. There was no synthesis of information provided in the document with data for the five individuals. This would not be considered an adequate DUE without further information, including the reason this study was chosen given such a small number of individuals were affected, goal of DUE, and action plan based on findings in this small study. This appeared to be a database search without further evaluation or demonstration of impact on the PCP practice patterns. Additionally, more information needed to be submitted in to provide evidence of DUE reviews including the following: background information (research) reviewed including references, a blank copy of the template of questions to be reviewed, the number of individuals on the medication being reviewed, the number of individuals chosen for the study, the sampling methodology for the sample, the results and interpretation of results. Questions should be asked during the evaluation that require an appropriate sampling of active records applicable to the diagnosis, use of measurable objective indicators, along with threshold compliance goals. Following a formal written report, the documentation should be presented at the P&T Committee in a timely manner, with documentation of discussion and outcome/goals established if areas needing improvement were found, and the date and focus of any follow-up study. Additionally, it is recommended that a template be used to document DUEs and a separate template for DUE follow-ups in order to differentiate the two for tracking purposes. Four DUEs are required as part of the Settlement Agreement each year, in addition to any DUE follow ups. On a positive note, a follow-up to the use of Divalproex sprinkle capsules through a G or J-tube was presented at the October 1, 2013 P&T Committee meeting. This was a follow-up to a DUE completed in 2012. From October 2012 through September 17, 2013, the use of Divalproex sprinkle capsules had reduced from 262 sprinkle capsules to six. This demonstrated the Facility could use the DUE process as a successful QI tool with clinical impact. The Facility lost its substantial compliance rating with this provision. This was due regression in performance. Specifically, it was due to a lack of quarterly DUEs being completed, as well as a lack	

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<tr><td></td><td></td><td>of documentation showing the methodology, results, presentation at the P&T Committee, and follow-up plans for DUEs.</td><td></td></tr>
<tr><td>N8</td><td>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.</td><td><u>Policies and Procedures regarding Medication Variances</u>
Two policies were updated concerning medication administration. One was entitled “Health Care Services: M.20 - Medication Administration Guidelines,” revised 3/7/13, approved 3/7/13, and implemented 3/7/13. Revisions in the policy included ensuring medical supplies such as cleaning agents, shampoos, and thickening powder were not expired, and if so, were returned to the Pharmacy.

The second policy was a new procedure dated June 2013, “State Supported Living Center Procedure: Medication Administration Observation Guidelines.” The staff completing the observation, training requirements for medication administration, and frequency of monitoring were included. The steps of the medication observation also were outlined, along with scoring of competency.

<u>Pharmacy Review of Categorization of Errors</u>
The Pharmacy Department was active in verifying that the Nursing Department’s categorization of medication errors was consistent with the Pharmacy’s interpretation of the medication error categorization. The CNE and the Clinical Pharmacist discussed coding of the error reports. Findings were recorded in the Medication Committee meeting minutes. It was noted that there were few changes identified per month (zero to two changes in categorization were made per month).

<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, which the CNE chaired. Since the Monitoring Team’s last visit, the committee met on 4/29/13, 5/29/13, 6/27/13, and 7/23/13. The following describes some of the findings of this committee:

<table>
<tr><th>Month</th><th>Pharmacy Department</th><th>Nursing Department</th><th>Medical Department</th><th>Dental Department</th><th>Total</th></tr>
<tr><td>January 2013</td><td>5</td><td>697</td><td>NS*</td><td>NS</td><td>702</td></tr>
<tr><td>February 2013</td><td>1</td><td>114</td><td>NS</td><td>NS</td><td>115</td></tr>
<tr><td>March 2013</td><td>15</td><td>395</td><td>NS</td><td>NS</td><td>410</td></tr>
<tr><td>April 2013</td><td>17</td><td>182</td><td>NS</td><td>NS</td><td>199</td></tr>
<tr><td>May 2013</td><td>13</td><td>323</td><td>NS</td><td>NS</td><td>336</td></tr>
<tr><td>June 2013</td><td>8</td><td>349</td><td>NS</td><td>NS</td><td>357</td></tr>
<tr><td>July 2013</td><td>11</td><td>566</td><td>NS</td><td>NS</td><td>577</td></tr>
</table>
*NS = not recorded/not submitted</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Month	Category A	Category B	Category C	Category D	Category E
January 2013	4	677	10	11	0
February 2013	2	104	9	0	0
March 2013	391	14	5	0	0
April 2013	191	0	7	1	0
May 2013	320	13	2	1	0
June 2013	0	8	349	0	0
July 2013	0	13	564	0	0

Month	Excess unknown returns (doses)	Unknown shortage (doses)	Medication Administration Record (MAR) not initialed	Documented omission
January 2013	667	7	170	15
February 2013	117	39	139	5
March 2013	281	107	175	3
April 2013	154	21	236	1
May 2013	315	5	173	1
June 2013	340	5	103	3
July 2013	556	2	180	4

The monthly "Medication Error Summary" reports were helpful in understanding the charts and graphs provided. These monthly Medication Error Summary reports were more easily interpreted, and data from these reports were entered into the tables above. Other charts and graphs were used as confirmation.

However, there were several inconsistencies across documents. For example, in one medication error table, un-reconciled errors for July/June/May/etc. were listed as June/May/April/etc. in another medication error table. The monthly medication error summaries at times listed omissions as including blank MARs, and later as omissions determined by evidence. The narrative in some Medication Committee minutes did not agree (e.g., March MAR not initialed = 179) with the March 2013 Medication Error Summary (March MAR not initialed = 175). Providing explanation of the charts and graphs would have been beneficial, as the context was difficult to interpret at times.

Additionally submitted were monthly "Medication Reconciliation" forms listing 16 categories of irregularities. This categorization allowed tracking of reasons for returned medications or medication shortages.

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		To further reduce the medication variances, the Pharmacy Department had designed a system to have the medications counted by pharmacy staff and nursing at the time of cart fill and with every medication dispensed. This was to be implemented as of 9/1/13. To improve medication variance and accountability, the 4/29/13 Medication Committee minutes indicated that the Pharmacy was doing sweeps of the medication rooms to check for eye drops, creams, etc., to ensure these medications were given as ordered. One pharmacist was assigned to check, dispense, and label medications. Each medication was to be labeled in the same manner consistently. The label for the medications was to print the date dispensed. Medications were not dispensed without a date of dispensing. According to the "Medication Variance Report from January – April 30, 2013," the Pharmacy conducted weekly inspections of the medication rooms. The pharmacy inspections included removal of old products. The Pharmacy provided, in table format, a number of medications with the reasons for concern and removal identified. Medications included mineral oil (33 concerns), eye drops and lubrication (68 concerns), and ergocalciferol drops (40 concerns). Concerns included: older than December 2012, no pharmacy label, lot number missing/covered, discard date missing/covered, label not acceptable, excess quantity, and expired medication. From the 6/27/13 Medication Committee meeting minutes, the Pharmacy had converted ferrous sulfate, docusate, Milk of Magnesia, and Mylanta to unit dose to create more room on the medication cart, decrease spillage, and improve accountability. It was noted that Keppra was changed to a liquid form and there might have been an increase in seizures documented. Based on this concern, an action plan was developed to ensure the liquid medication was being given as ordered. Staff from the Pharmacy and Nursing Departments were to be assigned to monitor the bottles of medication. This endeavor had not started as of the date of the committee meeting. From the 7/23/13 medication committee minutes, the Pharmacy was to implement a counting process for medications dispensed outside of the cart exchange. The Pharmacy Department provided a list of action steps taken to reduce medication variances at CCSSLC since the Monitoring Team's last visit. These were as follows: ▪ Reduction of the numbers of floor stock drugs. This reduced the time spent maintaining, reordering, and removing expired medication; provided the first dose of medication for symptoms; and allowed for improved rotation of stock. It was limited to frequently used over-the-counter medication with some exceptions. ▪ For the Coral Sea Unit, cart exchanges were reduced to a three and four-day fill cycle, due to the number of doses administered. ▪ The designation of the time for administering new orders was coordinated with the Nursing Department. ▪ Corrections to the MAR were coordinated with the Pharmacy each month.	

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		▪ With few exceptions, the oral inhalants, oral liquids, and solids were dispensed in unit dose. Creams/ointments were issued in unit dose or the smallest unit of measure. Liquid medications were provided in unit dose cups, repackaged into oral syringes for doses smaller than five milliliters, or the manufacturer's smallest package. These changes allowed for several potential positive outcomes, including improved accountability, reduced time in medication administration, exact doses being identified for each medication pass (point of administration), a standardized volume was provided reducing the errors of measuring medication at each dose, and each unit dose was in the individual's medication bin/drawer. ▪ Review of the drug regimen through the QDRR process resulted in a reduction in doses of medication, and reviewing and researching guidelines for specific medications (i.e., review of calcium supplementation, mineral oil eardrops, proton pump inhibitors, etc.). ▪ Medication room inspections (either weekly or monthly) ▪ Pharmacy on-duty hours extended to 2200 each business day. And 0800 to 1500 on Saturdays. <u>Medication Room and Cart inspections by Nursing Department</u> Medication Rooms and Cart inspections were conducted monthly. It was not clear if the Nursing Departmental staff were completing these inspections. The charts, both entitled "Medication Area Inspection Record Compliance Data," were submitted, and did not always include the month of the audit. Two audit tools were submitted to review these areas, one with 33 compliance indicators and one with 29 compliance indicators. Thirteen medication rooms were inspected during each campus survey. For March 2013, areas of concern included the following: Emergency medication kit seal is unbroken (50%), cabinets and shelves are clean (77%), medication room floor is clean (77%), medication cart is clean and free of medication residue and dust (85%), controlled substances are stored under a double lock and counted each shift, signed and co-signed (62%), medication cart open containers are labeled with date opened and initialed (85%), refrigerator/freezer temperatures are recorded daily (62%), refrigerator/freezer is clean/defrosted (67%), drugs are properly provided (i.e., protected from light, refrigerated, upright, closed, other) (85%), excess quantities of floor stock drugs are removed, floor stock drug list posted in each clinical area (85%), and prescription drug hand-off occurred (83%). For inspections discussed in April 2013 (the charts were not dated), areas needing improvement included: opened containers are labeled with date opened and initialed (82%), cabinets and shelves are clean (73%), medication cart is clean and free of medication residue and dust (70%), controlled substances are stored under a double lock and counted each shift, signed and co-signed (73%), medication cart open containers are labeled with date opened and initialed (73%), and refrigerator/freezer temperatures are recorded daily (82%). For inspections discussed in May 2013 (the charts were not dated), areas needing improvement	

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		included: opened containers are labeled with date opened and initialed (82%), cabinets and shelves are clean (73%), medication cart is clean and free of medication residue and dust (70%), controlled substances are stored under double lock and counted each shift, signed, and co-signed (73%), medication cart open containers are labeled with date opened and initialed (73%), refrigerator/freezer temperatures are recorded daily (82%), and refrigerator/freezer is clean/defrosted (82%). For inspections discussed in June 2013 (the charts were not dated), areas needing improvement included: controlled substances are stored under a double lock, and counted each shift, signed and co-signed (69%), biohazard container for used needles is available (85%), refrigerator/freezer temperatures are recorded daily (85%), equipment checks: glucometer controls checked per policy (82%), and prescription drug hand-off occurred (78%). There appeared to be several months with the same areas of non-compliance. There was no information provided or discussed at the committee meetings to aggressively address these areas (i.e., creating system changes to resolve repeat occurrences). <u>Medication Error Reports</u> Copies of the last 10 medication error forms were submitted for review. The Monitoring Team member reviewed and classified the medication variances according to the State Office policy/guideline. There were zero Class A medication errors, one Class B medication error, nine Class C medication errors, and zero Class D medication errors. There were eight omissions of which only one was categorized correctly as Class C. The Nursing/Pharmacy Departments had categorized the eight omissions as Class B. Nine different medications were involved in these 10 medication variances. Brief follow-up was documented on 10 of 10 medication error forms. <u>Medication Observation Monitoring</u> Tables per residential unit were submitted indicating the number of medication observations completed per month, as well as the sample size these observations represented based on the number of nurses for whom an observation of medication pass was due. Whether the PNMP was being followed during the medication administration was also noted. Data was submitted monthly for January 2013 through July 2013. Listed were the descriptions of the concerns found and the report was broken down according to Unit. The overall medication pass score for Atlantic Unit was 95 to 100 percent, for Pacific Unit was 95 – 100 percent, for Coral Sea was 97 – 99 percent, and for the Infirmary was 74 – 100 percent. Concerns related to medication observation monitoring are discussed with regard to Section M.6. In summary, the Facility had identified and was in the process of implementing some action steps to try to address identified concerns related to medication variances. However, it was not yet clear that these actions were sufficient to rectify the significant numbers of medication variances,	

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		particularly unexplained returned medications. In other instances, auditing showed problems (e.g., medication room audits), but documentation was not presented of actions being developed and implemented. In addition, the Facility was not consistently correctly classifying medication errors. The Facility remained in noncompliance with this provision.	

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 O.1 (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual # 315, and Individual #247) and an additional three individuals who received direct OT/PT therapy (i.e., Individual #87, Individual #99, and Individual #301), including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of Interdisciplinary Team members required to attend the annual ISP meeting, 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 ISP and ISP Addendums for past year, Integrated Risk Action form, IDT Risk Action Plan/Integrated Health Care Plan, Integrated Progress Notes (IPNs) 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, PNMT 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 five individuals in Sample O.2 (i.e., Individual #138, Individual #224, Individual #348, Individual #87, and Individual #301) on the PNMT caseload who were assessed or reviewed in the last six months. In addition, a sample of three individuals who had been discharged by the PNMT (i.e., Individual #144 and Individual #155, and Individual #273), including: Preferences and Strengths Inventory, list of assessments/reports needed for the annual ISP meeting, list of IDT members required to attend the annual ISP meeting, 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 ten individuals in Sample O.3 (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #179, Individual #299, Individual #327, Individual #301, Individual #134, and Individual #68) including: OT/PT comprehensive assessment, OT/PT assessment of status, OT/PT update, Nutrition assessments, APEN assessment/tool, SLP comprehensive assessment, SLP assessment of status, SLP update, HOBE assessment, annual ISP and ISAs for past year, Integrated Risk Action form, IDT 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, 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 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 PNMPs for the following 41 individuals: Individual #285, Individual #367, Individual #35, Individual #67, Individual #282, Individual #200, Individual #159, Individual #45, Individual #198, Individual #304, Individual #136, Individual #326, Individual #202, Individual #65, Individual #327, Individual #141, Individual #356, Individual #194, Individual #179, Individual #209, Individual #301, Individual #359, Individual #87, Individual #153, Individual #200, Individual #251, Individual #348, Individual #138, Individual #16, Individual #93, Individual #212, Individual #307, Individual #207, Individual #368, Individual #287, Individual #99, Individual #313, Individual #145, Individual #158, Individual #106, and Individual #243; o List of Physical and Nutritional Management Team members and curriculum vita; o List of all individuals seen by the PNMT; 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 in which PNMT members participated; 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 that 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 percent 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 Monitoring Team's 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 Quality Assurance/Quality Improvement (QA/QI) 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 PNMP templates since the Monitoring Team's last review; o QA/QI Quarterly Section Review for Section O; o Number of new staff who successfully completed New Employee Orientation (NEO) PNM foundational performance check-offs (n), over number of staff in NEO over last six months (N); o Number of current staff who have successfully completed PNM performance check-offs (n), over number of current staff (N); o 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; o License numbers of PNMT core members; 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); o List of PNM monitors, and for each monitor listed, include date of NEO training competencies completed, and check-offs completed for validation and inter-rater agreement; o PNMT meeting minutes and attendance sheets completed after submission of pre-review document request; o NEO training curriculum for PNM foundational training; o QA/QI Indicators for Sections O, P, and R; o HOB priority list, criteria for placement on list, and date of HOBE assessments of individuals completed to-date; o Facility's policies/procedures related to Physical Nutritional Management (PNM) and PNMT beyond HT Department policies; o Facility and PNMT systemic issue documentation for menu and diet textures; o PNMT meeting minutes from August 3, 2013 to the present; o HOBE database evaluation status; o Status of placement of inclinometers and future placement; o Training documentation with dentist for placement of inclinometer; o Copy of Facility Policy I 006.3; o List of 15 individuals with custom positioning devices for future provision of individual-specific training; o Handouts for Facility-based Section I training; and o Copy of ISP Guide.

	▪ **Interviews with:** o Dr. Angela Roberts, Director of Habilitation Therapy; 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 multiple residences, dining rooms, and day programs; and o PNMT meeting, on 10/1/13.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, updated 9/13/13. 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: ▪ Based on a review of the Facility Self-Assessment, as well as interviews with the Director of HT, the following was found: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Monitoring Tool for Section O. The quarterly monitoring results were presented at the QA/QI meeting to facilitate integration amongst the different Plan of Improvement sections. In addition, multiple Facility-developed audit tools (i.e., PNMT assessment, PNMP) and HT database reports were implemented to assess compliance. o The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking attendance at PNMT meetings, review of PNMT referrals, PNMT assessment and PNMP audit tool, etc. The data presented reflected the Facility's assessment of its compliance status with the subsections of Section O. o The monitoring and audit tools included adequate methodologies, such as observations, record review, and staff interview. o The Self-Assessment identified the sample sizes used to complete audits. For a number of samples, the number in the sample (n) was identified in comparison with the total population size (N). o The Settlement Agreement Monitoring Tool for Section O had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, the PNMT assessment audit tool did not have instructions, standards, and/or methodologies. o The following staff/positions were responsible for completing the audit tool: The Director of HT, therapists, and a PCM. o The Director of HT and the Facility Program Compliance Monitor continued to achieve a high level (i.e., exceeds 85%) of inter-rater agreement. ▪ The Facility used other relevant data sources, including, for example, NEO and annual refresher staff training databases; data related to IHCPs, PNMPs, and IRRFs; continuing education database,

	Facility PNM policies, etc. ▪ The Facility presented some of the data in a meaningful/useful way with the exception of not distinguishing data collected by the QA Department or the HT Department. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured 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. The Director of HT and the Facility PCM provided an analysis of the Section O Monitoring results that identified the potential causes for the issues with plans to ameliorate non-compliance findings.
	Summary of Monitor's Assessment: The Facility's PNMT had the required core members as outlined in the Settlement Agreement, and was meeting regularly. Medical providers attended the IDT/PNMT meeting to discuss the findings of the PNMT assessment, RN Case Managers attended PNMT Meetings and provided medical follow-up, PNMT members indicated there was accessibility to medical providers and consultants, and the PNMT Nurse and/or designee attended daily morning medical meetings to obtain individual-specific updates on individuals who had experienced a change in status. The DADS At Risk, Physical Nutritional Management, and Quality Assurance policies and multiple CCSSLC policies/protocols were comprehensive and included necessary PNM policy elements. Individuals who met the PNMT referral criteria had not been consistently referred to the PNMT. However, for those individuals that had been referred, the PNMT members had made substantial progress in the completion of comprehensive PNMT assessments. In June 2013, an audit tool for the PNMT assessment that included necessary assessment components had been developed and implemented, which seemed to have helped. Based on the Monitoring Team's review, compliance for 31 of 33 PNMT assessment elements was 100%. Additional work will be required to establish and/or review individual-specific clinical baseline data to assist teams in recognizing changes in health status, and develop measurable outcomes related to individual-specific clinical indicators, including but not limited to when nursing staff should contact the PNMT. These improvements were extremely encouraging, and with the addition of these elements, the assessments would include all necessary components. Additional work also needed to be done to integrate PNMT recommendations in IHCPs and, most importantly, implement them. Since the Monitoring Team's last review, progress continued to be made with individuals' PNMPs having more of the necessary elements. The Facility had developed and implemented a process that alerted staff to PNMP revisions and their responsibility in the implementation of an individual's PNMP when revisions had been made.

	The Monitoring Team, the PNMT OT, and Facility therapists completed multiple direct observations of staff's implementation of individuals' PNMPs and dining plan strategies. A mealtime observation in the Coral Sea dining room showed excellent implementation of the PNMPs. Individuals were correctly positioned in their wheelchairs, prescribed adaptive equipment was present, staff were following dining plan presentation techniques, and communicating with individuals during the meal. However, observations in the Infirmary, in the Pacific dining room, and in other parts of the residences in Pacific and Coral Sea revealed that staff often did not follow prescribed PNMP strategies, which had the potential to place individuals at risk. The Facility was providing PNM foundational training during NEO and annual refresher training. Individual-specific training was being provided to individuals. However, the Monitoring Team was not able to discern from the documentation submitted if all required staff had successfully completed performance check-offs for individuals who's PNMP strategies required individual-specific training. Individuals in Sample O.1 and O.2 were not monitored for the effectiveness of their progress in relation to their physical and nutritional management needs, nor was evidence provided that interventions were modified if an individual was not making progress. More specifically, the implementation of 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 Facility maintained an updated list of individuals who received enteral nutrition. Individuals in the sample, who received enteral nutrition, were reviewed by their IDTs. However, the annual assessment did not include necessary elements. Individuals who were transitioning to oral eating did not have formal plans.

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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	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 chosen from a list the Facility provided 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, or osteoporosis], requiring mealtime assistance and/or prescribed a dining plan, at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room, and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. These 15 individuals were: Individual #122, Individual #79,	Noncompliance

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	Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual # 315, and Individual #247. ▪ **Sample O.2** consisted of individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. This sample included five individuals: Individual #138, Individual #224, Individual #348, Individual #87, and Individual #301. In addition, a sample of three individuals who had been discharged by the PNMT was selected, including: Individual #144, Individual #155, and Individual #273. ▪ **Sample O.3** consisted of 10 individuals who received enteral nutrition. These 10 individuals were: Individual #122, Individual #79, Individual #340, Individual #273, Individual #179, Individual #299, Individual #327, Individual #301, Individual #134, and Individual #68. Some of these individuals were included in one of the other samples. ▪ **Sample O.4** consisted of 41 individuals (i.e., Individual #285, Individual #367, Individual #35, Individual #67, Individual #282, Individual #200, Individual #159, Individual #45, Individual #198, Individual #304, Individual #136, Individual #326, Individual #202, Individual #65, Individual #327, Individual #141, Individual #356, Individual #194, Individual #179, Individual #209, Individual #301, Individual #359, Individual #87, Individual #153, Individual #200, Individual #251, Individual #348, Individual #138, Individual #16, Individual #93, Individual #212, Individual #307, Individual #207, Individual #368, Individual #287, Individual #99, Individual #313, Individual #145, Individual #158, Individual #106, and Individual #243) observed in the residences, dining rooms, and day programs. This included random, individual-specific observations as well as observations of individuals in Sample O.1 and 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,	

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		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 submitted the following policies: ▪ State Policy 012.3: Physical Nutritional Management, effective 3/4/13; ▪ State Policy 006.3 At Risk Individuals, effective 12/7/12; ▪ State Policy 003.1 Quality Assurance, effective 1/26/12; ▪ CCSSLC Administration: Compiling and Reporting Plan of Improvement Data, revised 5/5/12; ▪ CCSSLC Medication Administration Observation Guidelines, dated June 2013; ▪ CCSSLC Health Care Guidelines – Medical and Nursing: Nutritional Management Planning Process Criteria, LL.20, implementation date 12/5/10; ▪ CCSSLC Health Care Guidelines – Medical and Nursing: Physical Management Overview, LL.24, implementation date of 12/5/10; ▪ CCSSLC Health Care Guidelines – Medical and Nursing: Physical Management Process Criteria, LL.25, implementation date of 12/5/10; ▪ CCSSLC Physical and Nutritional Management: Roles of PNMT Members, implementation 5/31/11; ▪ CCSSLC Physical and Nutritional Management: Participating in PNMT meetings, O.2.1, revised 12/8/10; ▪ CCSSLC Occupational and Physical Therapies: Training Staff on Physical Nutritional Management Plans, P.2, revised 6/13/13; ▪ CCSSLC Occupational and Physical Therapies: Documenting Meal Monitoring, P.4, revised 5/25/12; ▪ CCSSLC Dental Services: Standard of Care – Dental, Q.14, revised 10/28/11; ▪ CCSSLC Dental Services: Tooth Brushing, Q.20, implementation date of 10/28/11; ▪ CCSSLC Dental Services: Chlorhexidine with Suction Brush Protocol, Q.21, implementation date of 7/8/11; ▪ CCSSLC Occupational and Physical Therapies: Maintaining Adaptive – Assistive Equipment, P.3, revised 5/2/13; ▪ CCSSLC Occupational and Physical Therapies: PNMP Clinic Minutes Instructions, P.3.2, drafted 3/26/13 ▪ CCSSLC Occupational and Physical Therapies: Documenting Meal Monitoring, P.4, revised 5/25/12; ▪ CCSSLC Occupational and Physical Therapies: Ensuring Safe Practices During Meals, P.5, revised 4/23/12; and ▪ CCSSLC Occupational and Physical Therapies: Competency of Staff Implementing Indirect Services Programs, P.7, draft 3/27/13.	

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		CCSSLC had established PNM policies that included the following elements, though some of these were included in the DADS At-Risk Policy, Physical Nutritional Management, and QA Policy: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan; ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with ▪ Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia (not stated specifically in the policy, but clearly in practice); ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable QA system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns: 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	

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		identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Providers meeting, QA/QI meeting); o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; 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. ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide); o Identification of monitors and their roles and responsibilities; o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the 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. The Facility had a comprehensive PNM policy, which included the preceding elements. **Core PNMT Membership** The CCSSLC PNMT had 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. Although not a requirement of the Settlement Agreement, back-up members had been identified for each position. **Consultation with Medical Providers and IDT Members** The Facility reported the PNMT did not have any medical providers assigned as consultants to the PNMT. However, PNMT members stated that they had accessibility to medical providers (primary care physicians) and medical consultants if they had	

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		questions and/or needed guidance for individuals on their caseload. The Facility Self-Assessment indicated for six of seven (86%) individuals, evidence was provided of medical providers' routine participation in meetings, review of assessments, and other needed activities. For four the five individuals in Sample O.2 (i.e., Individual #138, Individual #224, Individual #301, and Individual #348 (80%), evidence was provided of participation by medical providers (primary care physician) in the review of the individual's initial PNMT assessment. There was no attendance by a physician and/or a nurse practitioner at follow-up meetings, but RN case managers did attend these meetings to provide updates for individuals on the PNMT caseload. The PNMT Meeting minutes provided updates from completed medical appointments and consultations. The RN Case Manager was able to communicate with the individual's primary care physician if questions arose during the meeting that could not be answered. In addition, the PNMT Nurse and/or a designee attended the daily morning medical meetings to receive current updates on individuals who had experienced a change in status. The PNMT Nurse also provided members of the morning medical meetings an update on the status individuals on the PNMT caseload every Friday morning. For five of the five (100%) individuals in Sample O.2, evidence was provided of routine participation of other IDT members (i.e., QIDP, RN Case Manager, and Psychologist/Psychology Assistant) in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Five of five (100%) PNMT core members were licensed to practice in the state of Texas. Five of five (100%) PNMT core members had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. 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 concerns. **Continuing Education** Four of five (80%) PNMT staff 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 PNMT RD was a contract staff member. The Facility began to require contract staff to submit documentation for continuing education courses completed effective September 1, 2013. Attendance rosters, course certificates of completion, and agendas were submitted and reviewed. ▪ PT attended: Habilitation Therapies Conference (9/20/12), NPO [nothing by	

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		mouth] Recommendations from the MBSS for Adults (1/26/13), Falls and Balance Disorders (3/8/13), and Neuro Rehabilitation Conference 2013; ▪ SLP attended: Habilitation Therapies Conference (9/20/12), Practical Activities for Milestone Development (11/8/12), NPO [nothing by mouth] Recommendations from the MBSS for Adults (1/26/13), and Neuro Rehabilitation Conference 2013; ▪ OT attended: Habilitation Therapies Conference (9/20/12), Texas Occupational Therapy Conference (11/2/12), NPO [nothing by mouth] Recommendations from the MBSS for Adults (1/26/13), Falls and Balance Disorders (3/8/13), and Neuro Rehabilitation Conference 2013; and ▪ RN attended: Medication Administration for Nurses (9/19/12), Annual Habilitation Therapies Conference (9/20/12), NPO [nothing by mouth] Recommendations from the MBSS for Adults (1/26/13), and Neuro Rehabilitation Conference 2013. **PNMT Meetings** From April 9, 2013 to September 24, 2013, the PNMT met 95 times. These meetings included 14 Core PNMT meetings, 76 follow-up meetings, four pre-assessment meetings, and one discharge meeting. Attendance by core PNMT and back-up members for 95 meetings conducted during the time frame from April 9, 2013 to September 24, 2013 was: ▪ RN: 43% attendance by core member, 55 %for back-up member, 98% overall; ▪ RD: 100% attendance by core member; ▪ PT: 96% attendance by core member; ▪ OT: 77% attendance by core member, 29% for back-up member, 100% overall; and ▪ SLP: 93% percent attendance by core member. The attendance percentage, including core PNMT members with back-up members attending when core PNMT members were not present, exceeded 90% overall. The Facility Self-Assessment reported that PNMT meeting minutes documentation lacked outcome/progress toward established goals and exit criteria, reporting on the status of individuals' clinical health indicators, assessment to determine if individuals were better or worse, and did not include an analysis of the efficacy of their interventions. The PNMT Meeting Minutes format, undated, had been revised to include a section for analysis of information and exit criteria. These revisions were effective. Based on the Monitoring Team's review of PNMT meeting minutes, they presented information on PNMT referrals and possible discharges, individual-specific information from hospital rounds, and post-hospitalization results, reports on resolution of systemic	

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		issues, and PNMT actions and follow-up. However, there were missing elements. The review of the PNMT minutes identified the following concerns: ▪ Individual-specific clinical health indicators had not been consistently identified; ▪ The absence of these clinical indicators made it difficult for the PNMT to discern if the individual had become "better or worse. The clinical indicators were needed to enable nursing to notify the PNMT of a change in status; ▪ The meeting minutes did not identify individual-specific triggers to be monitored by direct support professionals; ▪ It was challenging to identify an individual's progress toward established goals; and ▪ Exit criteria were not consistently defined. As a result, none of the 95 (0%) PNMT meeting minutes (April 2013 to September 2013) consistently included documentation of all appropriate topics. They did include information on: a) referrals; b) PNMT actions; and c) follow-up, but did not include sufficient information on: a) review of individual health status; and b) outcomes/progress toward established goals and exit criteria for individuals in the sample. **Resolution of Systemic Concerns** In response to a previously identified systemic concern, the PNMT assessment template had been revised to include the results of environmental monitoring. PNMT members and/or PNMP Coordinators completed the Respiratory Environment Rating Scale form, not dated. The PNMT completed environmental monitoring as part of the initial PNMT assessment. As of February 2013, the PNMT was no longer responsible for the completion of environment assessments on a routine basis. The completion and inclusion of environmental monitoring results was a positive addition to the assessment process. The Respiratory environment Rating Scale form had the following rating scale: ▪ 1-Excellent (no action needed); ▪ 2-Satisfactory (routine schedule for cleaning); ▪ 3-Unsatisfactory (action today); and ▪ 4-At risk (immediate action). The Monitoring Team requested copies of environment surveys completed in the Infirmary for the month of September 2013. Four completed forms were submitted. Three of the four forms (i.e., dates of 9/6/13, 9/11/13, and 9/19/13) did not have a rating above two. The fourth form (i.e., date of 9/19/13) had scores of three (i.e.,	

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		unsatisfactory, action needed) for the following indicators: vents are clean and free of dust, furniture is clean and free of dust/debris, and wall hanging/decorations are clean and free of dust/debris. However, on October 2, 2013, during the Monitoring Team and the PNMT OT's observations in individuals' bedrooms in the Infirmary (i.e., Individual #327 and Individual #179), significant dust build-up was observed on window sills, top of light fixtures, fan grilles, and bed frames. Individuals with respiratory compromise were in these bedrooms. This unclean environment had the potential to place individuals with respiratory compromise at risk of harm. As discussed during the exit interview, there should be a sense of urgency to ensure individuals' environments are free of allergens. The Facility should increase its quality control measures to ensure healthy and clean environments for individuals with respiratory compromise. On August 12 2013, the Facility PNMT members identified systemic issues related to CCSSLC using an outdated menu and individuals receiving incorrect diet textures. This issue was brought to the attention of the Facility Director, and a meeting was convened that included the Facility Director, Director of HT, PNMT members (i.e., Dietician, PT), Program Compliance Monitor, Facility OT and SLP, and Director of Food Service. Meetings were held on August 12, August 14, and August 19, 2013 to problem solve these issues. A Corrective Action Plan indicated the completion of the following tasks: ▪ Revised CCSSLC Food Service Menu: 31-Day Cycle Menu developed and implemented; ▪ Development and completion of training for Food Service Department to present the revisions to the menu and why the changes were necessary; ▪ Food Service staff to complete NEO and annual refresher for PNM foundational skills to understand the importance of serving correct food textures and the risk of aspiration if food textures were not correct; and ▪ On 9/30/13, new CCSSLC menu was implemented campus-wide. This was a positive example of the PNMT identifying a systemic issue and working with Facility staff to reach resolution in a timely manner. The Facility PNMT had a sustainable system fully implemented for resolution of systemic issues/concerns. In summary, the Facility had made progress within this section. At the time of the Monitoring Team's review, the Facility's PNMT had the required qualified core members as outlined in the Settlement Agreement, and was meeting regularly. Four of the five PNMT members had completed continuing education relevant to physical and nutritional supports that were transferrable to the population served, within the past 12 months. The Facility had put a system in place to track related continuing education for contract	

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		staff. State and Facility policies addressed the necessary PNM policy elements. The PNMT members were identifying systemic issues and working with Facility staff to reach resolution. However, additional work needed to be completed to achieve substantial compliance in this section. PNMT meeting minutes should at a minimum include: review of individuals' health status, and outcomes/progress toward established goals, and exit criteria for individuals. 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 physical and nutritional management problems to identify the causes of such problems.	**Identification of PNM Risk** The Facility HT database produced the following reports that identified individuals who required mealtime assistance, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who were at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"): ▪ Modified Liquids Report; ▪ Adaptive Dining Textures Report; ▪ Individuals Identified as Requiring Mealtime Assistance; ▪ Individuals Using Specific Positioning Equipment/Instructions (this list was for individuals who required positioning assistance associated with swallowing by maintaining elevation of their head. These individuals either had a hospital bed for the elevation, anti-reflux pillow, or supine positioner to maintain the elevation); ▪ Individuals Identified with Diagnosis of Dysphagia; ▪ Individuals At-risk of Receiving a Feeding Tube; and ▪ Integrated Risk Ratings - by Home. The Facility HT Database provided a sustainable system for maintaining and updating these lists. However, the Facility did not have policies and/or procedures that defined the process for maintaining this sustainable system. **Physical and Nutritional Management Team Referral Process** Individuals in Sample O.1 were reviewed to determine if they had been appropriately referred to the PNMT, based on the Facility policy. Four of nine individuals that should have been referred to the PNMT were appropriately referred (44%). More specifically: ▪ Six individuals (i.e., Individual #79, Individual #305, Individual #315, Individual #356, Individual #181, and Individual #222) did not meet the referral criteria. ▪ Four individuals (i.e., Individual #340, Individual #179, Individual #247, and Individual #153) were referred and/or reviewed by the PNMT based on the referral criteria. ▪ Five of the 15 individuals met the referral criteria and should have been referred to the PNMT, but were not: o Individual #122 was diagnosed with aspiration pneumonia on 6/13/13	Noncompliance

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		and 6/18/13 (i.e., TX-CC-1309-XII.15.m). She should have been referred to the PNMT. o Individual #273 was diagnosed with aspiration pneumonia on 7/12/13. He should have been referred to the PNMT. Although the State Office policy indicated referrals should be made after two diagnoses of aspiration pneumonia in a year, the Monitoring Teams have indicated that given the risk aspiration pneumonia poses to individuals, any diagnosis of aspiration pneumonia should result in a referral to the PNMT. o Individual #299 had a Stage II decubitus with an onset date of 6/20/13. The Skin Integrity Meeting – Decubitus/Pressure Ulcer Report, not dated, indicated his date of resolution was "in progress." He should have been referred to the PNMT as a result of the delayed healing for his decubitus. o Multiple individuals experienced unplanned weight loss of 10% or greater over a six month period. These individuals should have been referred to the PNMT: ▪ Individual #24 had an 11.4% weight loss from February 2013 to July 2013. ▪ Individual #369 lost 18.3% of her body weight from February to July 2013. For none of the one individual (i.e., Individual #340) (0%) referred to the PNMT as noted above, a referral had been made within five working days of an ISP and/or ISPA meeting. There was no ISPA meeting to discuss his PNMT referral of 7/20/13. Individual #153 had been referred to the PNMT on 1/29/13. The Monitoring Team requested six months of documentation (i.e., April through September). Consequently, it could not be verified if an ISP and/or ISPA meeting had been convened to discuss the referral to the PNMT for Individual #153. The following metrics were not applicable as no individual had received a non-emergency placement of a feeding tube and/or an emergency tube placement since the last review: ▪ ___ of ___ (%) individuals who received an emergency feeding tube placement since the last Monitoring Team review had been referred to the PNMT after the emergency feeding tube placement. ▪ ___ of ___ individuals (%) 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. **PNMT Assessment**	

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		For the five individuals in Sample O.2, three of five PNMT assessments (60%) (i.e., Individual #224, Individual #87, and Individual #301) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). Three of five (60%) (i.e., Individual #138, Individual #224, and Individual #87) PNMT assessments were completed in no more 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: ▪ Five of five (100%) contained date of referral by the IDT; ▪ Five of five (100%) contained the date the assessment was initiated; ▪ Five of five (100%) contained evidence of review and analysis of the individual's medical history; ▪ Five of five (100%) identified the individuals' current risk rating(s), including the current rationale; ▪ Five of five (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data; ▪ Five of five (100%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; ▪ Five of five (100%) contained assessment of current physical status; ▪ Five of five (100%) contained assessment of musculoskeletal status; ▪ Five of five (100%)) contained evaluation of motor skills; ▪ Five of five (100%) contained evaluation of skin integrity; ▪ Five of five (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; ▪ Five of five (100%) contained evaluation of current adaptive equipment. ▪ Five of five (100%) contained nutritional assessment, including, but not limited to history of weight and height, intake, nutritional needs, and mealtime/feeding schedule; ▪ Five of five (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; ▪ One of one (100%) (i.e., Individual #301) identified residual thresholds, if enterally nourished. This metric was not applicable for four individuals (i.e., Individual #138, Individual #224, Individual #348, and Individual #87) as they ate orally; ▪ Five of five (100%) contained a tableside oral motor/swallowing assessment,	

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		including but not limited to mealtime observation. ▪ Five of five (100%) contained respiratory status; ▪ Five of five (100%) contained evidence of review/analysis of lab work; ▪ Five of five (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects; ▪ Five of five (100%) contained discussion as to whether existing supports were effective or appropriate; ▪ Five of five (100%) contained oral hygiene status; ▪ Five of five (100%) contained evidence of observation of the individual's supports at their residence and day/work programs; ▪ Five of five (100%) contained evidence that the PNMT conducted hands-on assessment; ▪ Five of five (100%) identified the potential causes of the individual's physical and nutritional management problems; ▪ Five of five (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individuals' identified problems, including an analysis and rational for the recommendations; ▪ Five of five (100%) contained recommendations for measurable skill acquisition programs, as appropriate; ▪ None of five (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; ▪ None of five (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT; ▪ Five of five (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); ▪ Five of five (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and ▪ Five of the five (100%) contained signatures with dates. In June 2013, an audit tool for the PNMT assessment that included necessary assessment components had been developed and implemented. The PNMT members had made substantial progress in the completion of comprehensive PNMT assessments. Based on the Monitoring Team's review, compliance for 31 of 33 PNMT assessment elements was 100%. Additional work will be required to establish and/or review individual-specific clinical baseline data to assist teams in recognizing changes in health status, and the develop measurable outcomes related to individual-specific clinical indicators, including but not limited to when nursing staff should contact the PNMT. These improvements	

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		were extremely encouraging, and with the addition of these elements, the assessments would include all necessary components. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For none of the five (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 two of the five (40%) (i.e., Individual #348 and Individual #301) individuals' plans reviewed, the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. ▪ For five of the five (100%) individuals for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. ▪ In none of the five (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. "Appropriate" is defined as objectives that are relevant to the PNM problem, and "functional" means, when appropriate, objectives that increase an individual's independence. ▪ In none of the five (0%) individuals' plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. For example: o Individual #138's PNMT assessment was completed on 6/6/13. He had been referred to the PNMT due to a prolonged hospital admission for pneumonia, which also resulted in a significant weight loss. The PNMT Meeting Minute Follow-up Review, dated 6/18/13, recommended an HOBE assessment be completed by 7/16/13. This timeframe for the completion of an HOBE assessment did not show the necessary sense of urgency for someone with this level of risk. o Individual #224's was referred to the PNMT for weight loss. Her PNMT assessment was completed on 4/30/13. Her PNMT Follow-up Review, dated 5/7/13, provided a due date for revision of her PNMP to clarify fluid restriction and staff in-service with a due date of 5/28/13, which did not show the necessary sense of urgency for someone with this level of risk. o The PNMT self-referred Individual #87 on 7/15/13 as a result of unplanned weight loss and history of severe PICA with severe consequences. The PNMT Follow-up Review, dated 8/6/13, recommended a change of status to increase risk of constipation/bowel obstruction from medium to high with a due date of 8/30/13. It was unclear why this was not resolved during the PNMT/IDT assessment meeting. This timeframe did not reflect a sense of urgency.	

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		○ Furthermore, PNMT recommendations had established due dates but many recommendations were labeled as "pending." The pending status often rolled from review to review without completion. This did not support a sense of urgency. ▪ In none of the five (0%) individuals' plans reviewed, the plans included the specific clinical indicators of health status to be monitored. ▪ In none of the five (0%) individuals' plans reviewed, the plans defined triggers. ▪ In none of the five (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 five (0%) individuals' documentation reviewed, supporting documentation was present to confirm implementation of individuals' action plans within 14 days, or sooner as needed, of the plan's finalization. The Monitoring Team was not able to discern if the PNMT action plans had been implemented within 14 days. ▪ In none of the five (0%) individuals' plans reviewed, documentation was provided to show action plan steps had been completed within established timeframes, or IPNs, consultations and/or follow-up reports provided an explanation for any delays, including a plan for completing the action steps. PNMT meeting minutes' follow-up reviews often noted that multiple due dates for the completion of individual-specific recommendation status were not met. These were labeled as "pending," and rolled from PNMT review to review without completion. The following comments are provided based on the reviews completed of individuals' PNMT plans (i.e., as provided in individual-specific PNMT meeting minutes): ▪ PNMT assessment recommendations were not consistently incorporated into plans. ▪ Recommendations were dropped from plans without explanation. ▪ Plans included multiple service recommendations, but did not consistently identify individual-specific baseline clinical indicators and then ongoing measurement of these indicators to enable the PNMT members to monitor the effectiveness of their recommendations. ▪ Individual-specific triggers were not identified in plans. ▪ Recommended PNMP monitoring was focused on mealtimes. ▪ Multiple recommendations were tracked from one PNMT meeting to the next, and labeled as pending, which did not support a sense of urgency for completion. ▪ Multiple plans with recommended integration of action steps in individuals' IHCPs had not been completed in a timely manner. For example, Individual	

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		#87's PNMT recommendations included: update IHCP to a measurable goal for respiratory compromise, choking/aspiration, dental, cardiac disease, weight, skin integrity. Four reviews (i.e., 8/6/13, 8/13/13, 8/20/13, and 9/17/13) noted that the recommendation for a measurable goal for respiratory compromise was pending for three of the reviews and the last review (i.e., 9/17/13) stated "in progress." **Individuals Discharged by the PNMT** Review of three individuals' PNMT discharge summaries (i.e., Individual #144, Individual #155, and Individual #273) and ISPAs found: ▪ None of the three (0%) individuals had a meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ None of the three (0%) individuals' discharge summary/action plans provided objective clinical data to justify the discharge. ▪ None of the three (0%) individual's ISPA meeting documentation provided evidence that any new recommendations, as appropriate, were integrated into the IHCP. ▪ Three of the three (100%) individuals' discharge summaries included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. In summary, the PNMT was to be commended for the substantial progress that had been made in improving the PNMT assessments, including consistently implementing 31 of 33 necessary PNMT assessment elements in all five PNMT assessments reviewed. This was a significant improvement from the last review. Additional work was needed to ensure IDTs referred individuals to the PNMT who meet referral criteria, PNMT action plan elements were all included, PNMT action plans were integrated into IHCPs, and individuals were properly discharged from the PNMT. The Facility remained out of compliance with Section O.2.	
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	**IDTs' Reviews of PNMPs** Two hundred and seventeen (217) of the 241 individuals (90%) living at CCSSLC had 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 non-attendance of therapists and/or dieticians. In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, residential staff, medical and nursing staff, and the physical and nutritional management team, as appropriate.	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.	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. 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. In many cases, the rationale for discipline-specific staff to not attend the annual ISP meeting was not adequate and/or was not present. Some examples included: ▪ Assessment is sufficient; ▪ Information will be obtained from assessment; ▪ Not at high risk in this area; and/or ▪ Habilitation Therapy representative will be attending. The absence of team members (i.e., RD, OT, PT, SLP, Dental, psychologist, and medical provider) impacted the team's ability to provide adequate input in a review of the effectiveness of an individual's PNMP and the need for revision of an individual's PNMP, if appropriate. The review of an individual's PNMP should be an important factor when identifying disciplines that should be present during the annual ISP meeting. None of 15 (0%) PNMPs in Sample O.1 were adequately reviewed by the individual's IDT in the annual ISP meeting. The following statement often was included in individuals' ISPs: "the IDT reviewed, updated, and approved the revised PNMP to ensure that all supports related to the individual's abilities, alignment, comfort, communication, mobility and safety have been addressed." This did not provide evidence that the IDT members addressed the effectiveness of the PNMP and/or discussed any updates and/or revisions to an individual's PNMP. This needed to include evidence of review of effectiveness as well as accuracy, updates/revisions agreed upon by the team, and specified changes required with rationale. **<u>PNMP Format and Content</u>** A review of 15 PNMPs for the individuals in Sample O.1 found the following: ▪ PNMPs for 15 of 15 (100%) individuals were current within the last 12 months. ▪ PNMPs for 15 of 15 (100%) individuals included a list of risk levels and triggers; ▪ In four of 15 (27%) PNMPs (i.e., Individual #122, Individual #273, Individual #369, and Individual #24), there were large and clear photographs with instructions. ▪ Seven of 15 (47%) PNMPs (i.e., Individual #273, Individual #24, Individual #305, Individual #299, Individual #356, Individual #315, and Individual #247) listed the adaptive equipment required by the individual with rationale. ▪ In six of 11 (55%) PNMPs for individuals who used a wheelchair as their primary mobility (i.e., Individual #122, Individual #79, Individual #340, Individual #179, Individual #305, and Individual #222), positioning instructions	

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		for the wheelchair, including written and pictorial instructions were provided. The PNMPs reviewed for the remaining individuals who used wheelchairs as their primary mobility did not include written and/or pictorial instructions for staff to achieve safe elevation ranges, and/or the frequency of re-positioning. Four individuals used a wheelchair for transport only (i.e., Individual #273, Individual #369, Individual #153, and Individual #315); ▪ In of 15 of 15 PNMPs (100%), positioning was adequately described per the individuals' assessments. A review of OT/PT assessments showed they did provide a description of alternate positioning, including safe elevation ranges, alternate, bedtime, other positioning as indicated, and as appropriate, non-foundational/individual-specific instructions. ▪ In 15 of 15 (100%) PNMPs, the type of transfer was clearly described, or the individual was described as independent. ▪ In five of 15 (33%) PNMPs (i.e., Individual #340, Individual #153, Individual #181, Individual #315, and Individual #247), bathing instructions were provided. For these individuals, instructions included bathing equipment, strategies, independence, and level of staff assistance required. ▪ In 11 of 15 (73%) PNMPs (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #53, Individual #305, Individual #299, Individual #356, Individual #181, Individual #315, and Individual #247), toileting-related instructions were provided, including check and change. For the remaining four individuals, no instructions were provided to identify the level of independence, degree of safe elevation, and/or level of staff assistance required during toileting. ▪ In 15 of 15 (100%) PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. ▪ In 15 of 15 (100%) PNMPs/dining plans, instructions related to mealtime were outlined, including for those who received enteral nutrition. ▪ Fifteen of 15 (100%) dining plans were current within the last 12 months. ▪ Eight individuals had feeding tubes with no oral intake (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #179, Individual #122, Individual #299, and Individual #247). One of eight (13%) (i.e., Individual #122) PNMPs/dining plans indicated the individual was to receive nothing by mouth. ▪ In five of 15 (33%) PNMPs/dining plans (i.e., Individual #122, Individual #79, Individual #179, Individual #24, and Individual #247), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. ▪ Seven individuals ate orally within this sample (i.e., Individual #369, Individual #153, Individual #24, Individual #305, Individual #356, Individual #181, and	

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		Individual #315). o In seven of seven (100%) PNMPs/dining plans for individuals who ate orally, diet orders for food texture were included. o In seven of seven (100%) PNMPs/dining plans for individuals who received liquids orally, the liquid consistency was clearly identified. o In one of seven (14%) (i.e., Individual #315) PNMPs/dining plans for individuals who ate orally, 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. The remaining five individuals' dining plans listed adaptive equipment, but no rationale was provided. ▪ In nine of 15 (60%) PNMPs (i.e., Individual #122, Individual #79, Individual #340, Individual #369, Individual #179, Individual #153, Individual #24, Individual #181, and Individual #247), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. ▪ In none of 15 (0%) PNMPs, oral hygiene instructions were included, including general positioning and brushing instructions. ▪ Fifteen of 15 (100%) PNMPs included information related to communication (i.e., how individual communicated, and how staff should communicate with individual). **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans (PNMPs), P.2, revised 6/13/13, outlined the steps to be followed to inform staff of an individual's PNMP revision. A copy of the revised PNMP and a new acknowledgment form was to be placed in the Individual Notebook and another copy was to be placed in the Medex. The Home Team Leader and/or designee were responsible for continuing the revised PNMP pass-down process at each shift change. The Nurse Case Manager or designee also would continue the pass-down process at each shift change. All direct contact staff, including nurses, were responsible to ensure they were aware of the individual's supports as listed on the PNMP as evidenced by their signature on the acknowledgment form attached to the back of the PNMP before assuming responsibility for an individual. Furthermore, the Residential Coordinators and PNMP Coordinators randomly spot-checked the PNMP acknowledgement forms to ensure staff working with the individuals had signed the PNMP acknowledgement form. Staff would be subject to disciplinary action for working with individuals if they had not signed the PNMP acknowledgement form. For the nine individuals in Sample O.1 with PNMPs for whom the IDT and/or PNMT identified changes needed to be made to the PNMP after the annual ISP meeting, nine of	

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		the nine (100%) (i.e., Individual #122, Individual #340, Individual #273, Individual #179, Individual #153, Individual #299, Individual #356, Individual #315, and Individual #247) had been reviewed and revised, and their records contained PNMP acknowledgement forms with staff signatures. Individual #79 was in the hospital, and the Individual Notebook was with the individual. Consequently, the PNMP acknowledgment form was not available for review. For individuals for whom the PNMP was revised, there was supporting documentation that nine of the nine (100%) individuals' revised PNMPs had been implemented as evidenced by the receipt of the revised PNMP by the home, and staff signatures that were in alignment with the PNMP revision date. Since the last review, progress had been made with individuals' PNMPs having more of the necessary components. A policy had been developed and implemented to alert staff to PNMP revisions and their responsibility in implementing those revisions. To achieve substantial compliance with this section, IDTs need to review and document their decisions about PNMPs, and PNMPs missing elements should be added to PNMPs. 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 provoke swallowing difficulties.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** Based on the Monitoring Team's observations during the onsite review, dining plans were accessible for staff reference. A mealtime observation completed by the Monitoring Team and a Facility OT and PT in the Coral Sea dining room showed that staff were consistently complying with dining plans. Individuals were positioned correctly in their wheelchairs, the prescribed adaptive equipment was available, and staff were following presentation techniques. However, mealtime observations conducted in the Pacific dining room revealed staff non-compliance with dining plans. Based on the Monitoring Team's observations in Pacific and Coral Sea, five of the 19 (26%) individuals (i.e., Individual #285, Individual #367, Individual #35, Individual #282, Individual #200, Individual #159, Individual 45, Individual #198, Individual #304, Individual #136, Individual #326, Individual #202, Individual #65, Individual #304, Individual #16, Individual #93, Individual #350, Individual #212, and Individual #307) dining plans were implemented as written (i.e., Individual #16, Individual #93, Individual #350, Individual #212, and Individual #307). Based on observations the Monitoring Team conducted with the PNMT OT and Facility therapists: ▪ None of 12 individuals (0%) (i.e., Individual #141, Individual #356, Individual #194, Individual #209, Individual #87, Individual #200, Individual #285, Individual #313, Individual #138, Individual #251, Individual #67, and	Noncompliance

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		Individual #145) were positioned correctly in their seating systems; ▪ None of three (%) individuals' alternate positioning plans (i.e., Individual #350, Individual #153, and Individual #348) were implemented as written. ▪ One of two (50%) pivot transfers (i.e., Individual #65) performed by staff were completed correctly; and ▪ In one of two (50%) observations of medication administration passes (i.e., Individual #141), the nurse followed procedures in the PNMP. The PNMP provides the foundation for health and safety. The observations the Monitoring Team completed showed that some staff were not competent and/or compliant in implementing foundational PNMP and dining plan strategies. This was concerning in that the staff's failure to implement PNMPs was an issue during the Monitoring Team's last onsite review, and, unfortunately, continued to be of concern during this review. The Facility should move forward to provide additional support to staff to enhance their competency in and/or require the implementation of PNMPs, most importantly, for those individuals at highest risk. As discussed with regard to Section O.5, the Facility continued to revise and improve a mealtime accountability system to support staff compliance with dining plans. To achieve substantial compliance within this section, the Facility should, with a sense of urgency, 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.	**New Employee Orientation (NEO) Orientation** NEO orientation should contain the following elements: ▪ Lifting and transfers; ▪ Positioning (e.g., alternate, wheelchair, and bathing/showering); ▪ Adaptive equipment; ▪ PNMP orientation and implementation; ▪ Safe mealtime strategies; and ▪ Basics of dysphagia. CCSSLC New Employee Orientation was provided across three eight-hour days for a total of 24 hours. CCSSLC new employee competency-based training incorporated the preceding PNM competency-based training elements and was comprehensive. All new employees were required to successfully complete 23 PNM foundational competency performance check-offs. Each performance check off had an established equivalency percentage score. For example, the two-person T lift check off required staff to complete 12 of 14 objectives for an equivalent percentage score of 86%. Equivalent percentage scores across the 23 check-offs ranged from 80 to 89%.	Noncompliance

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		The Facility Self-Assessment, updated 8/23/13, indicated that from 2/1/12 to 7/31/13, 135 of 155 new employees (87%) successfully completed the 22 PNM competency performance check-offs. The Facility also submitted a document (i.e., Explanation and Rationale for CBT [competency-based training] Training Program at CCSSLC, TX-CC-1309-XII.24a-d) that stated: "new employees are required to successfully complete all 23 PNM core competencies (performance check-offs), upon hire and before working with individuals." As indicated in the Monitoring Team's last report, the Facility reported from October 2012 through March 2013, 108 of 108 new employees (100%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. The percentage of new employees completing PNM foundational performance check-offs had decreased from 100% during the last review to 87% for this review. **PNM Core Competencies for Current Staff** CCSSLC revised their method of training in 2011 to meet the requirements of competency-based training. A curriculum was developed that identified the foundational skills and job performance tasks needed as a prerequisite for staff to implement PNMPs for individuals. The revised PNM foundational competency-based training for current staff was implemented from 10/3/11 to 11/4/11. Prior to the training, the Facility identified current staff positions that would be required to complete PNM foundational training. The Facility Self-Assessment reported that currently 723 of 728 veteran staff (99%) had successfully completed this training. The Facility reported during the last review that 754 of 754 (100%) had successfully completed PNM foundational training and check-offs. . Thirty-two of 32 staff (100%)responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. The Facility developed and implemented a PNMP Acknowledgement Sheet that was attached to an individual's PNMP. Staff signature on this form indicated that staff was aware of the specific physical and nutritional supports and services the individual required. This form also acknowledged that they were responsible for implementing the supports as they were written on the PNMP when working with an individual. **Annual Refresher Training** Current staff were responsible for completing 10 performance check-offs during annual refresher training. These 10 objectives included: two person transfer/lift, two-person manual lift, bed positioning, wheelchair positioning, stand-pivot transfer, mechanical lift, adaptive dining equipment, mealtime safety, Simply Thick, and communication. Since the last review, revisions had been made to the some of the performance check-offs. For	

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		example, the speech/language/communication check-off required staff to identify different ways individuals communicate; demonstrate an object cue, and a generic home communication board; identify unaided/aided AAC devices; provide definition of AAC; demonstrate use of AAC devices; and describe the purpose of and locate a Communication Dictionary. In addition, the curriculum had been expanded for bed positioning and the potential dangers of bed rails. These revisions were positive additions to the annual refresher training curriculum. The Facility Self-Assessment indicated that 704 of 728 current staff (97%) that required PNM foundational annual refresher training and performance check-offs had completed this training within the past 12 months. **Individual Specific Training** Initially, six individuals had been identified as requiring PNMP individual-specific training. Two of these individuals were in Sample O.1 (i.e., Individual #153) and Sample O.2 (i.e., Individual #301). As discussed below, an additional 15 individuals had since been identified. The Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans (PNMPs), P.2, described the provision of individual-specific training. When an individual's staff required individual-specific training, a therapist would provide competency-based training to a PNMP Coordinator. The PNMP Coordinator was responsible for demonstrating competency for the specific objective as well as teaching the objective (i.e., three-person transfer, custom right sidelying positioning device, dining presentation techniques, and lower body positioner). When this dual competency was achieved, the PNMP Coordinator was responsible for completing competency-based training with home staff. The policy stated that: "all staff who will work with an individual who requires individual-specific training must be trained ***prior to*** working with the individual." Individual-specific training documentation was reviewed for Individual #153 and Individual #301. These documents were reviewed to determine if all staff, who were present during a specific time period, had received individual-specific training. More specifically: ▪ Individual #301's staff received individual-specific training for special techniques to position him in a custom sidelyer positioner while in bed. A competency-based checklist was provided. A Facility OT and PT provided training to two PNMP Coordinators. PNMP Coordinators completed training on 9/24/13, and the PNMP Coordinators provided training to 31 home staff during the time period from 9/24/13 to 10/2/13. Individual-specific training was provided on supine positioning in bed with a custom lower body positioner. In addition, the Facility PT provided training to a PNMP Coordinator, and the PNMP Coordinator trained five staff on 10/3/13.	

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		▪ Individual #153's staff received individual-specific training for mealtime presentation techniques. A PNMP Coordinator provided training to eight staff during the time period from 6/13/13 to 6/21/13. An additional 15 individuals had been identified who will receive individual-specific training on their custom positioning equipment in the future. So, although it was positive that the HT Department staff was providing individual-specific training, additional work was needed to develop a system to ensure all required staff, including pulled staff, received individual-specific training for the individuals they supported on a daily basis. The Facility provided documentation for individual-specific training, however, the Monitoring Team was not able to assess the following metrics with the information provided. The following metrics will be assessed during the next review: ▪ 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. There were four occupational therapists, two Certified Occupational Therapy Assistants (COTA), three physical therapists, two physical therapy assistants (PTA), two speech language pathologists, two speech language assistants (SLA) and four PNMT members (i.e., OT, PT, SLP and Nurse) who provided individual-specific competency-based training and performance check-offs to PNMP Coordinators. Therapy support staff (i.e., PNMP Coordinators) responsible for training other staff had completed competency-based training and performance check-offs for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. The Facility had a written procedure that defined the validation process that staff responsible for training other staff was competent to assess other staff's competency. The Facility was providing PNM foundational training to new employees, and to veteran staff during annual refresher training. However, additional work needed to be done to ensure staff providing supports to individuals, successfully complete PNM individual-specific training. 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	**<u>Facility's System for Monitoring of Staff Competency with PNMPs</u>** The HT Department primarily used the Compliance Monitoring tool to monitor meals. The Compliance Monitoring form had instructions and identified additional indicators that were to be monitored for meal/snack, medication administration, oral care, positioning, lifting/transfer, bathing, and communication. Based on a review of the	Noncompliance

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	positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	monitoring form: ▪ Monitoring tools did include adequate indicators to determine whether or not "staff demonstrated competency in safely and appropriately implementing" mealtime and positioning plans. ▪ Monitoring tools did include adequate instructions. ▪ The staff conducting monitoring was competent in the areas they were monitoring. The monitors had completed competency-based training and performance check-offs by Facility therapists. However, the Monitoring Team had concerns with the validity of the monitoring data as discussed below. The Compliance Monitoring Level of Compliance - CCSSLC Audit by Individual HT database report, with a date range from 2/1/13 to 7/31/13, indicated that compliance monitoring had been completed 1113 times during this time period for 232 individuals. The report provided the following information by individual: monitoring date, home, type of monitoring, name of staff completing monitoring, identification of the shift on which the monitoring occurred, and the compliance score. The Monitoring Team's analysis of this report found the following: ▪ 1069 of the 1113 monitoring forms (96%) focused on oral intake (meals and snacks); ▪ None of the 1113 monitoring forms (0%) focused on bathing; ▪ One of the 1113 monitoring forms (less than 1%) focused on medication administration; ▪ None of the 1113 monitoring forms (0%)focused on oral care; and ▪ Three of the 1113 monitoring forms (less than 1%) focused on positioning. ▪ 69% (763/1111) occurred during first shift (Note: two monitoring events did not designate the shift during which the monitoring occurred); ▪ 26% (292/1111) occurred during second shift; and ▪ 5% (55/1111) occurred during third shift. In order to address various types of risk, for the first five indicators, approximately 50 to 60 percent of monitoring should occur during meals, including individuals that are enterally nourished, with others evenly distributed; and monitoring should occur across all three shifts, with approximately 15 percent on third shift, and evenly distributed across first and second shifts. As a result, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing and/or times of day. The following concerns were noted from the compliance monitoring database report: ▪ Three of the compliance monitoring forms were scored below 80% (i.e., Individual #297 on 7/31/13 with a score of 63%; Individual #138 on 6/6/13 with a score of 75%; and Individual #56 on 6/11/13 with a score of 67%). The	

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		remaining 1110 forms had the following compliance scores: o 12 of the compliance forms had a score of 80%; o Five had a compliance score of 88%; o 34 forms were scored at 89%; o 22 forms were scored at 90%; and o 1037 forms were scored at 100%. Given that the Monitoring Team was continuing to find concerns with staff's implementation of PNMPs, particularly in certain residences, the validity of these findings were questionable. ▪ The PNMP compliance monitoring during this time period did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, such as snacks, bathing, oral care, lifting/transfers. Due to the absence of monitoring within these areas, issues might exist that had not been identified; ▪ The monitoring for medication administration and positioning was not adequate; and ▪ The database did not identify for what type of positioning (i.e., wheelchair, bed, recliner, positioner) monitoring was completed. **<u>Monitoring for Individuals in Samples</u>** For 12 of the 15 (80%) (i.e., Individual #315, Individual #153, Individual #247, Individual #222, Individual #24, Individual #305, Individual #181, Individual #369, Individual #356, Individual #299, Individual #340, and Individual #273) individuals in Sample O.1, did the frequency of PNM compliance monitoring over the past three months occur as per the individuals' assessments and/or the individuals' plans/IHCPs. The following concerns were noted: ▪ Some individuals' OT/PT assessments did not recommend the frequency of meal monitoring to be conducted; ▪ Some individuals' OT/PT assessments recommended monthly meal monitoring, but monitoring was not completed monthly; ▪ OT/PT assessments only recommended meal compliance monitoring and did not recommend monitoring for bathing, oral care, wheelchair and alternate positioning, lifting/transfers, and/or medication administration; ▪ The majority of PNMP monitoring was completed during mealtimes. However, this was not adequate to meet the requirements of the Settlement Agreement; and ▪ IHCPs did not require PNMP monitoring with the exception of meal monitoring. For none of five (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.	

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		Monitoring should occur according to the schedule identified in policy and/or as individualized in the assessment and/or plan. The majority of recommended compliance monitoring for individuals in Sample O.1 was monthly meal monitoring. In cases where the individual's clinical acuity necessitates a higher frequency of monitoring, it should occur at this frequency. Based on review of information in the monitoring database: ▪ For the past three months, no problems were noted on any of the compliance meal monitoring forms for the individuals in Sample O.1. The Compliance Monitoring form required the development of a plan if the compliance score fell below 80%. ▪ None of these compliance form scores fell below 80%, and consequently, no plan was required. Therefore, the following metric was not completed: Of these, documentation of adequate follow-up was provided on ____ of the ____ forms that identified a concern (%). "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. In addition, the Facility should be able to present cumulative monitoring data. CCSSLC Occupational and Physical Therapies: Documenting Meal Monitoring, P.4, described the steps to complete meal monitoring. However, this policy was not comprehensive. At a minimum, such a policy should include: ▪ Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, oral care, personal care, wheelchair and alternate positioning, transfers, medication administration, etc.); ▪ Training and validation process by therapists (i.e., content experts) for monitors (i.e., PNMP Coordinators, Habilitation Therapy Technicians) to achieve accurate scoring and a high level of inter-rater agreement; ▪ Identification of PNM risk factors with high and/or medium risk ranking (i.e., aspiration pneumonia, respiratory compromise, choking) that require individual-specific enhanced PNMP monitoring; ▪ Formal schedule for monitoring to occur; ▪ Requirement that all monitoring forms provide instructions for individual monitoring indicators to support scoring consistency and inter-rater agreement; ▪ Auditing process of completed monitoring forms to ensure compliance with Facility policy; ▪ Development and implementation of a system to track and trend monitoring results to resolve individual-specific and systemic issues; and	

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		▪ Establishment of a threshold for staff re-training for monitoring results that demonstrate repeated staff non-compliance with PNMPs and therapy programs. In summary, the Facility had not yet developed and implemented a PNM monitoring policy with operational guidelines, including the necessary components. The HT Department was monitoring staff PNMP compliance for meals, but PNMP monitoring needed to be expanded to include bathing, oral care, medication administration, lifting/transfers, and wheelchair/alternate positioning. 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 15 (0%) individuals' records in Sample O.1, and none of five (0%) individuals in Sample O.2 contained evidence of indicators integrated as part of the IHCPs to assess the individuals' PNM status. None of the 15 (0%) individuals' records in Sample O.1, and none of five (0%) individuals in Sample 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 three (0%) individuals (i.e., Individual #87, Individual #99, and Individual #301) receiving direct therapy, 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 for the individuals in Sample O.1, the following metric 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. Trigger sheets and supporting documentation was reviewed for individuals in Sample O.1 and Sample O.2: ▪ None of 20 (0%) individuals' records included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. A review of IRRFs did not reveal a discussion of the need for individualized triggers for individuals at high risk. ▪ None of 20 (0%) individuals' Trigger sheets included individualized triggers as	Noncompliance

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		indicated. The trigger sheets reviewed had general triggers, but they were not individualized. In addition, individualized triggers on PNMPs were not reflected on trigger sheets. ▪ None of 20 (0%) individuals' Trigger sheets were completed correctly. A review of trigger sheets revealed gaps in documentation on the three shifts. ▪ None of 20 (0%) individuals' Trigger sheets were reviewed by the RN on a daily basis. A review of trigger sheets revealed gaps in documentation by direct support professionals and nursing. In summary, the Facility had not implemented an effectiveness monitoring system that included tracking of individualized clinical indicators and triggers to evaluate and report on the individuals' progress, and revise interventions, as appropriate. The Facility remained out of compliance with this provision.	
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 maintained a list of individuals who received enteral nourishment. The Facility had a sustainable system to maintain and update the list of individuals who received enteral nutrition. However, a Facility policy and/or procedure had not memorialized this sustainable system. A review was conducted of the nine individuals in Sample O.3 (Individual #122, Individual #79, Individual #340, Individual #273, Individual #179, Individual #299, Individual #301, Individual #134, and Individual #68). Individual #327 was initially included in Sample O.3, but was removed from Sample O.3. Her IRRF, dated 9/16/13, indicated she was receiving services from hospice, and the IDT had not completed an assessment of the medical necessity of her tube due to her current health status. Six of nine individuals (i.e., Individual #79, Individual #134, Individual #68, Individual #340, Individual #122, and Individual #273) (67%), who receive enteral nutrition, were evaluated at a minimum annually. The following three individuals did not have a current APEN data collection tool and/or a related discussion in the IRRF: Individual #301, Individual #179, and Individual #299. None of the nine (0%) individuals reviewed had an appropriate evaluation to determine the medical necessity of the tube. In order to determine medical necessity of enteral nutrition, documentation should include 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.	Noncompliance

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		The four individuals (i.e., Individual #17, Individual #98, Individual #27, and Individual #33) admitted since the Monitoring Team's last review ate orally and did not receive enteral nourishment. The following metric was not applicable for review: ▪ ____ 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. **<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u>** None of the nine (0%) individuals in Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. 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 the least restrictive schedule. Justification for/or against medication of formula/schedule should be included as part of assessment findings. Individual #134 (i.e., SLP progress note dated 8/20/13) and Individual #68 (i.e., SLP progress note dated 8/16/13) had been reviewed by the SLP to determine their candidacy for potential return to oral intake. Both of these individuals' pleasure feedings were recommended for discontinuation. As a result, the following metrics were not evaluated, but will be, as applicable, during the upcoming reviews: ▪ ____ of the ____(%) individuals 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. Based on information provided by the Facility, none of the two individuals had plans. The plan should include all of the following components: o Staff training required prior to implementation; o Staff roles and responsibilities (e.g., implementation and monitoring); o Time and schedule of interventions; o Specific triggers for when the plan should be stopped; o Milestones for progressing with the plan; o Documentation requirements (i.e., method for tracking progress); and	

#	Provision	Assessment of Status	Compliance
		o Frequency of subsequent assessments and staff responsible ▪ ____of the ____ (%) 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. ▪ ____ of the ____ (%) 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. ▪ ____ (%) 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 should include a return demonstration. ▪ ____ of the ____ (%) 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 with demonstrated competency in the plan. ▪ ____ of the ____ (%) individuals' plans were modified by the IDT. For ___ (___%) of these individuals' plans, the IDT met, reviewed and changed interventions, as appropriate, in a timely manner. Individuals' plans should be reviewed by the IDT to determine if the 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 it is a critical concern, when a change is indicated such as for a change in status or based on effectiveness monitoring findings. The Facility maintained and updated a list of individuals who received enteral nutrition. However, this process was not memorialized 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 necessary components. Individuals who were transitioning to oral eating did not have a formal oral intake plan that included the necessary components. The Facility remained out of compliance with this provision.	

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 #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual # 315, and Individual #247) and an additional three individuals who received direct OT/PT therapy (i.e., Individual #87, Individual #99 and Individual #301), 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 Health 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 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 issues, 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 OT/PT assessments for new admissions completed after the submission of the pre-document request; 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 Walter Shull, PT, Section P Co-Lead; and o Paul Osborne, PT, Section P Co-Lead ▪ **Observations of**: o Individuals in residences and dining rooms.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 9/13/13. 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: ▪ 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 an interview with the Director of HT, PCM, and Section Leads: o The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Section P Monitoring Tool, and Facility-developed audit tools. o The data presented in the Self-Assessment indicated that multiple audits were conducted using the OT/PT assessment audit tool, review of new admissions for timeliness of the completion of OT/PT assessments, audit of ISPs for incorporation of OT/PT recommendations, analysis of PNM foundational training databases for NEO and annual refresher training for PNM foundational training, etc. The data provided evidence that the Facility had assessed its compliance status with Section P. o The Self-Assessment identified the sample sizes used to complete audits. For example, the number of completed audits of assessments (n) was identified in comparison with the total number of assessments produced over the previous six months (N). o The Settlement Agreement Monitoring Tool for Section P had adequate

	instructions/guidelines to ensure consistency in monitoring and the validity of the results. However, the OT/PT Peer Assessment Audit tool did not have instructions, standards, and/or methodologies. o The following staff/positions were responsible for completing the audit tool: the Director of HT, therapists, and the PCM. o Adequate inter-rater reliability had been established between the Director of HT, therapy staff, and the PCM. The Director of HT and the Facility Program Compliance Monitor (PCM) continued to achieve a high level (i.e., exceeds 85%) of inter-rater agreement. ▪ The Facility used other relevant data sources, including, for example, information from the HT Department databases and/or spreadsheets. ▪ 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 Consistently measured 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 Section P.1, P.2, and P.3 of the subsections in Section P. Section P.4 was rated as not being in compliance. The Monitoring Team did not agree with the Facility's compliance findings for Section P.1, P.2, and P.3 for the following reasons: o Section P.1 – individuals' OT/PT assessments did not include necessary elements. Individuals who had experienced a change of status had not received an assessment of current status. o Section P.2 - Individuals receiving direct therapy did not have plans, and monthly progress notes were not completed. o Section P.3 - Substantial compliance with Section O.5 is the standard for compliance in this section. The Facility was not in substantial compliance with Section O.5, although significant progress had been made. Additional information is provided with regard to Section O.5. The Monitoring Team did agree with the Facility finding of not being in substantial compliance for Section P.4. However, the Facility did have a foundation developed for a sustainable system to monitor in multiple ways individuals' prescribed adaptive/assistive equipment. This monitoring system is described in further detail with regard to Section P.4. ▪ The Facility's data identified areas in need of improvement. For these areas of need, the Facility Self-Assessment provided 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. Since the last review, the Facility's OT/PT assessment content had improved. An OT/PT assessment audit tool had been developed and implemented. Individuals' OT/PT assessments were missing some of the required elements, and additional work was needed to ensure necessary assessments elements were completed. There were individuals who had experienced a change in status with an admission to the Infirmary and/or community hospital with PNM-related concerns who had not

	received an assessment update. Some individuals receiving direct OT/PT therapy interventions did not have plans. As a result, these plans and/or programs were not integrated into individuals' ISPs. In addition, monthly progress notes had not been completed to review 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, the Facility did not have an adequate monitoring system for PNMPs. However, the Facility did have the foundation in place for a sustainable system to monitor individuals' prescribed adaptive/assistive equipment.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**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 #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual #315, and Individual #247) 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], required mealtime assistance, and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who had experienced a change of status in relation to PNM concerns (i.e., admitted to an emergency room and/or hospital). Individuals within this sample might have met one or more of the preceding criteria. ▪ **Sample P.2** consisted of three of the four individuals (i.e., Individual #87, Individual #99, and Individual #301) who received direct OT/PT services. **Timeliness of Assessments** Four of four (100%) newly admitted individuals (i.e., Individual #17, Individual #98, Individual #27, and Individual #33) since the last review received an OT/PT assessment within 30 days of admission or readmission. Twelve of 15 (80%) (i.e., Individual #122, Individual #79, Individual #340, Individual #369, Individual #179, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, and Individual #247) individuals' OT/PT assessments and/or updates were dated as having been completed at least 10 days prior to the annual ISP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Fifteen of 15 (100%) individuals had received an assessment that was current within 12 months for individuals who were provided PNM supports and services. **<u>OT/PT Assessment</u>** Based on review of the sample of 15 assessments for individuals in Sample P.1, the comprehensiveness of the OT/PT assessments was as follows: ▪ Fifteen of 15 (100%) individuals' OT/PT assessments were signed and dated by both the OT and PT clinicians upon completion of the written report. ▪ Thirteen of 15 (87%) (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #24, Individual #305, Individual #222, Individual #299, Individual #181, Individual #315, and Individual #247) assessments included medical diagnoses and relevance to functional status. ▪ Twelve of 15 (80%) (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #24, Individual #305, Individual #222, Individual #299, Individual #181, and Individual #247) assessments 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. ▪ Twelve of 15 (80%) (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #24, Individual #305, Individual #222, Individual #299, Individual #181, and Individual #247) assessments addressed health status over the last year. ▪ Seven of 15 assessments (47%) (i.e., Individual #122, Individual #79, Individual #340, Individual # 369, Individual #305, Individual #222, and Individual #247) included a comparative analysis section that clearly analyzed the individuals' level of health status with previous years or assessments. The OT/PT assessment should provide an overview of an individual's health status over the past year and discuss the type of supports and services that have been implemented to minimize the impact on the individual's functional status. ▪ Fifteen of 15 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. ▪ Fifteen of 15 (100%) assessments listed medications and potential side effects relevant to functional status. ▪ Thirteen of 15 (87%) individuals' OT/PT assessments (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #181, Individual #315, and Individual #247) included individual preferences, strengths, and needs.	

#	Provision	Assessment of Status	Compliance
		▪ Fifteen of 15 (100%) assessments included evidence of observations by OTs and PTs in the individuals' natural environments (i.e., day program, home, work). ▪ Ten of 15 (67%) (i.e., Individual #122, Individual #79, Individual #369, Individual #179, Individual #153, Individual #24, Individual #222, Individual #356, Individual #181, and Individual #315) individuals' OT/PT assessments included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. ▪ Eleven individuals used a wheelchair as a primary mobility device. Eleven of the 11 assessments (100%) (i.e., Individual #122, Individual #79, Individual #340, Individual #179, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, and Individual #247) included a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. Four individuals (i.e., Individual #273, Individual #369, Individual #153, and Individual #315) did not use wheelchairs for their primary mobility. ▪ Five of 15 assessments (33%) (i.e., Individual #122, Individual #340, Individual #369, Individual #222, and Individual #181) included discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings. ▪ Fifteen of 15 assessments (100%) included recommendations for services and supports in the community. ▪ Three of 15 (20%) assessments (i.e., Individual #122, Individual #369, and Individual #222) included a comparative analysis of current functional motor and activities of daily living skills with previous assessments that clearly analyzed the individuals' level of functional status 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. ▪ Fifteen of 15 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that addressed the individuals' PNM risk levels; ▪ Two of 15 (13%) assessments (i.e., Individual #305 and Individual #299) included discussion of the individual's potential to develop new functional skills. 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.	

#	Provision	Assessment of Status	Compliance
		▪ Fifteen of 15 (100%) 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 provided clinical justification related to recommendations for direct therapy interventions and/or skill acquisition programs. ▪ Fourteen of 15 (93%) (i.e., Individual #122, Individual #340, Individual #273, Individual #369, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual # 315, and Individual #247) assessments included a monitoring schedule. The OT/PT assessment should recommend a monitoring schedule for the upcoming year for individuals with PNMPs. The therapist should describe the monitoring form(s) to be utilized. ▪ Fifteen of 15 (100%) assessments 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 needed were missing in the community. ▪ Fifteen of 15 (100%) assessments recommended ways in which strategies, interventions, and programs should be utilized throughout the day. The content of individual's OT/PT assessments had improved since the last review. The OT/PT assessment template had been revised to incorporate prompts for therapists to ensure the completed assessments included the necessary elements. In addition, an OT/PT assessment audit tool with these elements had been developed and implemented. There were nine individuals (i.e., Individual #79, Individual #273, Individual #369, Individual #179, Individual #24, Individual #299, Individual #356, Individual #315, and Individual #247), who had experienced a change in status (i.e., admission to the Infirmary and/or community hospital with a diagnosis related to PNM concerns) after the completion of these individuals' comprehensive OT/PT assessments. These individuals should have received an assessment update and/or consultation, but they did not. Consequently, the following metric could not be assessed due to the fact that assessment updates and/or consultations 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,	

#	Provision	Assessment of Status	Compliance
		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 required additional work to ensure necessary elements were present. Individuals who had experienced a change in status related to PNM concerns 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.	**Direct OT/PT Interventions** Four individuals received direct OT/PT intervention. Sample P.2 was comprised of three of these four individuals. The records of these individuals were reviewed resulting in the following findings: ▪ Two of the three individuals (i.e., Individual #87: increase strength, improve upper extremity function, and fine motor skills; and Individual #301: improve upper extremity function and postural position in wheelchair) were identified as receiving direct therapy, but the Facility indicated "no direct therapy plan and supports documentation for plan implementation is required" for Individual #87 and Individual #301. The Facility provided no specific justification for not developing plans for these individuals. A review was completed of the one plan that was submitted for Individual #99. ▪ For none of one (0%) (i.e., Individual #99) individual direct intervention plans could it be determined if they were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For none of one (0%) individual's record reviewed, the current OT/PT assessment and/or consultation 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 record reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. ▪ Individual #99's direct therapy had not been terminated. As a result, the following metric was not applicable: For ____ of ____ individual records whose therapies had been terminated (0%), 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 should discuss the recommendation to terminate the program within 10 working days, and the team's decision should be documented through an ISPA meeting.	Noncompliance

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		Indirect OT/PT Programs The implementation of these plans is discussed with regard to 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** Twelve of the 15 individuals' annual ISPs in Sample P.1 (80%) (i.e., Individual #122, Individual #340, Individual #273, Individual #179, Individual #153, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, Individual #315, and Individual #247) noted that the OT or PT attended the ISP meeting. An OT attended for Individual #273, Individual #315, and Individual #247. A PT attended for Individual #122, Individual #340, Individual #179, Individual #153, Individual #305, Individual #222, Individual #299, Individual #356, Individual #181, and Individual #247. No OTs and/or PTs attended for three individuals (i.e., Individual #79, Individual #369, and Individual #24). The ISP Preparation meeting documentation required OT attendance for Individual #79, Individual #369, Individual #24, and Individual #356, but no OT attended. PT attendance was required for Individual #79, Individual #369, and Individual #315, but no PT attended. For 10 individuals, the ISP Preparation meeting documentation did not require attendance of an OT and/or PT, but adequate justification was not provided (i.e., Individual #122, Individual #340, Individual #273, Individual #179, Individual #153, Individual #24, Individual #305, Individual #222, Individual #299, and Individual #181). 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. Three individuals in Sample P.2 had received direct therapy (i.e., Individual #87, Individual #99, and Individual #301). An OT and/or PT attended these individuals' annual ISP meeting. For individuals receiving OT/PT supports and services, 15 of 15 (100%) PNMPs were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. Ten individuals in Sample P.1 had their PNMPs revised after the annual ISP meeting (i.e., Individual #122, Individual #79, Individual #340, Individual #273, Individual #179, Individual #153, Individual #299, Individual #356, Individual #315, and Individual #247). For ten of ten individuals (100%), the revised PNMP was provided to the home and staff acknowledged the PNMP revisions by signing the PNMP acknowledgement form.	

#	Provision	Assessment of Status	Compliance
		For none of 18 individuals, (0%), the ISP, or an ISPA following the assessment/update, addressed recommendations outlined in the current OT/PT assessment. One of the 15 individuals' OT/PT assessments recommended skill acquisition programs (i.e., Individual #305). In one of the one (100%) (i.e., Individual #305) ISPs or ISPAs reviewed, skill acquisition programs that had been recommended in the OT/PT assessment were present. For none of three individuals (0%), the ISP/ISPAs contained measurable objectives related to interventions. None of the three (0%) individuals receiving direct OT/PT services was provided with comprehensive progress notes (IPNs) at least monthly. 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; and ▪ Be completed on at least a monthly basis. Based on the therapist's monthly data, if a lack of progress is noted, team review should occur 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. For individuals with PNMPs or SAPs (i.e., indirect OT and/or PT programs), for none of the 15 individuals (0%), monthly documentation from the OT and PT and/or QIDP was present, including the following: ▪ Information regarding whether the individual showed progress with the stated goal(s), including a summary of 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. Two of the three individuals receiving direct OT/PT intervention did not have plans, and concerns existed with the one plan that was available. Comprehensive progress notes were missing for direct as well as indirect OT/PT supports. The Facility remained	

#	Provision	Assessment of Status	Compliance
		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.	**Competency-Based Training** Competency-based training for, and monitoring of, continued competency and compliance of direct support professionals related to implementation of PNMPs were addressed in detail with regard to Section O.5. Substantial compliance with O.5 is the standard for compliance with this section.	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. The Facility's monitoring of PNMPs primarily focused on mealtimes, which was not adequate PNMP monitoring. The status of PNMP monitoring is addressed with regard to Section O.6. The Facility submitted the following policies for Occupational and Physical Therapy: ▪ CCSSLC Occupational/Physical Therapy Services, Policy 014, implementation date 10/7/09; ▪ CCSSLC Occupational and Physical Therapies, P.2, revised 6/6/13, and implemented 6/13/13; ▪ CCSSLC Occupational and Physical Therapies: Informing Staff on Physical Nutritional Management Plans, revised 6/6/13, and implemented 6/13/13; ▪ CCSSLC Occupational and Physical Therapies: Maintaining Adaptive – Assistive Equipment, P.3, revised 11/12/12, and implemented 12/3/12; ▪ CCSSLC Occupational and Physical Therapies: Adaptive/Assistive Equipment Supply Lists, P.3.1, revised 5/6/13; ▪ CCSSLC Occupational and Physical Therapies: PNMP Clinic Minutes Instruction, P.3.2, drafted 3/26/13; ▪ CCSSLC Occupational and Physical Therapies: Ensuring Safe Practices During Meals, P.5, revised 4/23/12; ▪ CCSSLC Occupational and Physical Therapies: Ordering and Repairing Beds, P.6, implemented 10/1/12; ▪ CCSSLC Occupational and Physical Therapies: Repairing Beds Protocol, P.6.1, implemented 3/7/13; and ▪ CCSSLC Occupational and Physical Therapies: Competency of Staff Implementing Indirect Services Programs, P.7, draft 3/27/13. The Facility did have a comprehensive OT/PT policy or set of policies and procedures which included the following elements:	Noncompliance

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		▪ Description of the role and responsibilities of OT/PT; ▪ Referral process and entrance criteria; ▪ Discharge criteria; ▪ Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; ▪ Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; ▪ Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; ▪ Identification of monitors and their roles and responsibilities; ▪ Definition of a formal schedule for monitoring to occur; ▪ Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; ▪ Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; ▪ Identification of the frequency of assessments; ▪ Definition of how individuals' OT/PT needs will be identified and reviewed; and ▪ Requirements for documentation for individuals receiving direct services. HT staff prescribed and provided all original equipment to an individual's home. Individuals' prescribed adaptive/assistive equipment was monitored by PNMP Coordinators and/or therapists using the following forms: ▪ Monthly Person-Specific PNMP Check Sheet, revised 3/27/13; ▪ Monthly Home Equipment Check Sheet; ▪ PNMP Clinic Minutes; and ▪ PNMP data sheets. The PNMP Coordinators were responsible for completing the Monthly Person-Specific PNMP Check Sheet on a monthly basis. The PNMP Coordinator was supposed to notify the prescribing therapist and Home Team Leader of any identified problems. Therapists had five working days to review the form and ensure problems were corrected. If the issues could not be resolved within five working days, a plan and/or course of action to correct the problem was to be developed, including an estimated completion date. In addition, the Facility policy required the PNMP Coordinator Supervisor to accompany the PNMP Coordinator once per month to provide oversight of the adaptive equipment monitoring process. A review of Monthly Person-Specific PNMP Check Sheets found 15 of 15 individuals (100%), positioning devices and mealtime adaptive equipment identified in the PNMP were monitored for cleanliness and proper working condition. If a problem was	

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		identified during the monitoring, it was referred to a Residential Supervisor and primary therapist for resolution. The CCSSLC Occupational and Physical Therapies: Maintaining Adaptive –Assistive Equipment, P.3, identified the steps to be completed for resolution of the identified problem. The completed Monthly Person-Specific PNMP Check Sheet was entered in the HT database. Reports were generated that identified the following: date reviewed, type of equipment, equipment status (i.e., replacement needed, damaged/needs repair), name of staff completing assessment and monitoring, action taken, date action initiated, proposed resolution date, comments/special instructions, date resolved, staff verifying equipment, days to action, and days to resolution. The report also provided the following data totals: ▪ Number of issues identified; ▪ Number of issues resolved to date; ▪ Number of issues unresolved to date; and ▪ Number of corrective actions overdue. The HT database Adaptive Equipment Check Report with a date range of 4/1/13 to 10/4/13 was provided for each of the individuals in Sample P.1. For the two of 15 individuals in the sample for whom adaptive equipment was noted to be in disrepair or needing replacement (i.e., Individual #356 and Individual #305), for two of two individuals (100%), equipment was repaired or replaced within 30 days unless justification was provided or unless the issues impacted the individual's health or safety, then action was taken within 48 hours. However, a review of the HT database from 4/1/13 to 10/4/13 identified the following concerns: ▪ Repairs/replacements identified on Monthly Person-Specific PNMP Check Sheet were not consistently tracked on the Adaptive Equipment Check reports. ▪ For multiple individuals, Individual-specific Adaptive equipment Check Reports indicated repairs and/or replacement exceeded 30 days without providing justification (e.g., wheelchair cleaning, headrest and/or footrest repair, positioning pictures, etc.). However, as stated in the Monitoring Team's last report, the HT database report for all Technician Work Orders indicated that 100% of the repairs for 286 individuals had been completed within 30 days or less. The HT technicians should review these reports to determine if recommended repairs and/or replacement had been competed related to individuals' wheelchairs and/or mobility devices. ▪ Multiple individuals were recommended to receive anti-entrapment bedrails. According to the documentation submitted, orders for bedrails were placed in May 2013, although many individuals did not receive bedrails until mid-September 2013. None of the individuals' reports provided an adequate justification for this delay.	

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		The Adaptive Equipment Check Report format included comprehensive data points to track the completion of recommended repairs/replacement for adaptive equipment. However, additional work will need to be completed to decrease the amount of time for the completion of repairs and/or replacement of individuals' adaptive/assistive equipment and to provide justification for repairs/replacement that exceed 30 days. The HT database report of All Technician Work Completed for CCSSLC and Group Homes From 5/1/13 to 7/31/13 tracked the completion of 450 work orders. Four hundred forty-seven (447) of 450 work orders (99%) were completed within 30 days. Many of these work orders were completed in one day, which was significantly below the 30-day threshold. However, the Adaptive Equipment Check Report identified multiple requests for repairs and/or modifications to individuals' seating systems that were not completed in 30 days. The Assistive Technology staff should review this database to determine if the wheelchair repairs and/or modifications have been completed. The Wheelchair/Mobility/Assistive Equipment Work Order form identified if the work order was for a repair, modification and/or new seating system. The requested order's priority was ranked as high (i.e., emergency and will be addressed in three days), medium (will be addressed within 30 days), and low for wheelchairs that had been identified in need of replacement but did not pose an adverse risk to the individual. An order of priority was maintained for individuals' wheelchair replacement. Wheelchair/Mobility/Assistive Equipment Work Order forms were completed for eight individuals in Sample P.4 (i.e., Individual #247, Individual #315, Individual #24, Individual #340, Individual #222, Individual #273, Individual #122, and Individual #299). Eight of eight individual's work orders were completed in less than 30 days and in some cases were completed within one day. A draft copy of CCSSLC Occupational and Physical Therapies: PNMP Clinic Minutes Instructions, P.3.2, provided instructions to therapists for the completion of the PNMP Clinic Minutes form. The form had been revised to include the numbers of Monthly Person-Specific PNMP Check Sheets and Monthly Data Sheets that had been reviewed. Facility therapists completed this form during a PNMP clinic. Individuals' equipment was assessed for fit, function, effectiveness, and condition. Facility staff indicated that if an individual's ISP was held prior to July, August, or September 2013, the PNMP Clinic minutes would have been purged from the individual's record. PNMP Clinic Minutes were submitted for three of the 15 individuals (i.e., Individual #222, Individual #369, and Individual #340). The PNMP Clinic Minutes provided an additional annual review and oversight completed by therapists of individuals' prescribed equipment.	

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		In summary, the Facility had developed the foundation of a sustainable system to monitor the condition, availability, and effectiveness of individual's prescribed equipment. However, a review of the Facility's individual-specific adaptive equipment check reports noted that additional work needed to be done to ensure repairs and/or replacements were completed with 30 days. If this timeline was exceeded, adequate justification needed to be provided. As discussed with regard to Section O.6, the Facility did not have an adequate monitoring system for PNMPs, as the primary focus was meal monitoring. The Facility remained out of compliance with this section.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Any policies, procedures and/or other documents addressing the provision of dental care, including for updated policies/procedures/protocols, highlighted areas of approved change; o List of staff in the Dental Department, including names, title/role, and degrees; o List of staff in the Dental Department and their CPR certification status; 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 make-up 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 confirming 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. A copy from dental office record of visit and copy from active record of same visit, including source of documentation (i.e., IPN or dental section of active record/dental office record) for: Individual #37, Individual #101, Individual #70, Individual #349, Individual #348, Individual #42, Individual #255, Individual #77, Individual #110, Individual #159, Individual #311, Individual #186, and Individual #12; o Five most recent off-site oral surgery consults and progress notes past six months: Individual #224, Individual #158, Individual #34, Individual #332, Individual #72; 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 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 (i.e., prophylaxis, annual, etc.), name, 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 reasons for missed appointments other than refusals per date for past six months, including reason for appointment (i.e., prophylaxis, annual, etc.); o List of no shows/missed appointments other than refusals per building per month for the last six months; o List of refusals per building 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 last six months, including any ISPAs that documented discussion/action plans concerning dental refusals and other dental missed appointments; o For five most recent emergency exams, IPN from start of emergency to closure, and copy of Dental Department evaluation and treatment including time and date of first symptom/concern, and time/date first seen in the dental office for: Individual #242, Individual #90, Individual #7, Individual #87, and Individual #191; 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 five 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 (i.e., medical, anesthesia clearance, etc.), and post-operative checklist or monitoring forms, IPNs on date of procedure, etc., for: Individual #145, Individual #334, Individual #190, Individual #115, and Individual #53; o For the past six months, copies of any correspondence concerning restraint and sedation use at time of office visit (i.e., to QDDP, team, psychologist, etc.); o For five 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 #154, Individual #97, Individual #93, and Individual #321; 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, second opinion, and subsequent documentation until closure, for: Individual #215, Individual #242, Individual #177, Individual #119, and Individual #28; o List of those who receive suction tooth brushing treatment; o List of those who have been identified as benefiting from suction tooth brushing treatment but who are not receiving suction tooth brushing at time of the Monitoring Team's visit (i.e., waiting for equipment, training, care plan revision, etc.); o Copy of 10 annual dental assessments completed in last 30 days and for the prior year of these same individuals: Individual #297, Individual #147, Individual #101, Individual #79, Individual #126, Individual #366, Individual #102, Individual #23, Individual #348, and Individual #146; 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 for all individuals, including copies of these annual exams (including odontogram); o Copy of 10 most recent annual dental summaries provided for the ISP submitted for the following individuals: Individual #12, Individual #132, Individual #189, Individual #55, Individual #20, Individual #307, Individual #113, Individual #333, Individual #237, and Individual #37; o The most recent/current Facility oral hygiene data for all individuals in past year, including numbers and percentages of good, fair, poor ratings, with date of data; also, a list of individuals for whom an oral hygiene rating was not obtained during this time; o For those individuals for whom care plans/ISP indicate they brush their own teeth, the oral hygiene scores, with dates of the scores, over the prior one year; o List of those individuals that floss their own teeth; o List of individuals provided instructions on flossing with dates of training; o For those individuals that brush their own teeth but do not floss, the reason for not flossing their own teeth. Requested submitted information included whether a skill acquisition plan had been created or implemented for flossing; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list of reasons with documentation as indicated; o Summary information on desensitization plans since Monitoring Team's last visit, including any evidence of implementation of plan, progress logs, etc.; o For those undergoing Total Intravenous Anesthesia (TIVA), any incident of injury in 24

	hours following TIVA administration in prior six months; o For those with documented pneumonia, for each individual, date pneumonia documented, date of the most recent 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; o For the self-assessment process: list of monitoring/audit tools used; for each tool, identification of the total number of the eligible population to be sampled, the number of the sample, clarification of how the sample was chosen, the frequency of data collection, the staff that completed the audit/monitor survey/review, and whether any inter-rater reliability data was obtained/analyzed for the audit/monitoring review; o For the self-assessment process, a list of the databases utilized (other than audit information), including title of each database/chart/table with date range of each database, and for data collected periodically rather than continuously, the frequency of data collection; o Presentation Book for Section Q; o Criteria for eligibility for suction tooth brushing; o Chlorhexidine with suction brush protocol; o Evidence for self-assessment for Section Q; o Roster for hands-on training in Units and roster for new employee orientation for oral hygiene; o Roster for chair-side training in dental clinic; and o Copy of dental in-service for new employee orientation. ▪ **Interviews with**: o 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: o The monitoring/audit tools the Facility used to conduct its self-assessment included: 17 components audited monthly. Some of the components had several subcomponents. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The indicators appeared to include the scope of dental services. o The monitoring tools included adequate methodologies, such as record reviews, from both the active record and the dental record. o The Self-Assessment identified the samples 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. o Instructions/guidelines for completion of these several audits were not submitted. o The following staff/positions were responsible for completing the audit tools: Registered Dental Hygienist.

	○ The staff responsible for conducting the audits/monitoring had clinical experience in the relevant area(s). The Facility did not have processes in place to ensure that staff that completed monitoring were competent as monitors. ▪ The Facility used other relevant data sources to show whether or not the intended outcomes of the Settlement Agreement were being reached. A total of 26 databases reflecting various aspects of dental services were available. Dental training databases were also current. 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 being in noncompliance with Section Q. This was consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. For those areas of need, the Facility Self-Assessment provided an analysis of the information, identifying for example a trend toward decreased training of direct support professionals, or a slowly negative trend in oral hygiene ratings.
	Summary of Monitor's Assessment: The Dental Department was well-organized department and provided a breadth of dental services. Databases were available to track each of the main aspects of dental care. These databases appeared current and accurate. The Dental Department had ongoing support of the data analyst in developing the databases and measurements needed for tracking baseline services and progress. The Dental Department demonstrated that they had used this information to improve the dental services. The Dental Department had been able to identify areas of need and challenge, and had already begun to act on these areas, prior to the Monitoring Team's visit. There were a few areas of concern or challenge remaining. Constant attention to training of new employees, as well as confirming completion of refresher courses by staff was an ongoing challenge. The database tracking appeared to be thorough. Continuation of the development of desensitization programs as well as tracking of success with the skill acquisition plans and staff supported objectives needed continued focus and ongoing support from all departments. In an administrative area, the Dental Department had 40 policies in draft phase, which needed to be completed, approved, trained, and implemented. Additionally, as noted in examples provided with regard to Section I, it was problematic that the IDT (including the dental representative) documented that dental supports were adequate for individuals having recently undergone extractions or having poor oral hygiene ratings. When applicable, the Dental Department needed to assist and direct the IDT in identifying additional supports for these individuals with undesirable outcomes in oral health.

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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, a certified dental assistant (CDA), two certified dental medication aides (CMAs), and two registered dental hygienists (RDHs) staffed the Dental Department. CPR certification was submitted for the Dental Department staff. From a document entitled "CPR Information for Medical Department," as of 7/31/13, there were seven staff listed in the Dental Department. All were current in CPR certification. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from 1/16/13 through 9/3/13 in a document entitled "Exams that were due in February 2013 [sic]" with run date of 9/9/13. The content included dental exams completed from 1/16/13 through 9/3/13, with the prior exam date (not just February 2013) for each of the most recent completed annual dental exams. This was reviewed to determine timeliness of annual examination completion. The most recent two dates were taken from the list to determine whether the most recent annual dental exam was within 365 days of the prior annual dental exam. The list included names of 176 individuals. None of these had database errors/typographical errors. Seven were new admissions during this time period and did not have a prior annual dental exam to determine timeliness. One additional annual dental assessment was placed on hold due to prolonged medical illness. Of the remaining 168 individuals listed, all 168 had prior annual examination dates listed. Of these 168, 167 (99%) had an annual examination date completed within 365 days of the prior annual exam. There was one overdue annual examination. Separately, the Dental Department submitted a document entitled "Dates of dental record annual examination/assessments in the past six months," with run date of 9/9/13. The additional information provided by this document was the date of the completed assessment form/dental summary (submitted for the ISP process) compared to the date of the dental examination. The goal, as of 6/10/13, was to have the assessment document completed within 30 days of the annual dental exam. From the dental exams of 2/1/13 through 6/10/13, there were eight dental exams that exceeded the 30-day limit. After 6/10/13, there were no dental assessments completed more than 30 days after the dental exam. Separately, a more recent sample of annual dental assessments/summaries was reviewed to determine timeliness. Copies of 10 annual dental assessments/summaries that were completed in the 30 days prior to the Monitoring Team's visit were submitted. The dates of these assessments/summaries were compared to the dates of the prior assessments/summaries to determine timeliness of completion. For 10 out of 10 (100%) of these individuals, an annual dental assessment/summary had been completed within 365 days. The time between the dental evaluation and the completion of the annual dental assessment/summary ranged from eight to 19 days. The Dental Department documented that there were no individuals residing at CCSSLC who had not	Noncompliance

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		seen a dentist in the prior 365 day time period of 8/1/2012 through 7/31/2013. The content of the submitted document "Annual Dental Summary" was the document submitted to the IDT as part of the ISP process. This document included the following components: ▪ Ten of the 10 (100%) submitted assessments had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Ten of the 10 (100%) submitted assessments had entries for oral hygiene rating. ▪ Ten of the 10 (100%) submitted assessments for individuals with teeth had entries for teeth restorations, and periodontal condition. ▪ Zero were edentulous. ▪ Ten of the 10 (100%) submitted assessments had entries for oral cancer screening (i.e., intra-oral exam and extra oral exam screening/soft tissue exam). ▪ Of those with teeth, a periodontal chart or periodontal screening/probe record was not included in the records. However, 10 of 10 (100%) included pocket depth. ▪ Ten of the 10 (100%) submitted assessments documented a summary of findings/treatment during the annual visit. ▪ Ten of the 10 (100%) submitted assessments documented a summary of findings/treatment during other dental visits. Zero of the 10 were only seen at the annual dental assessment. ▪ Ten of the 10 (100%) submitted assessments included a dental treatment plan. ▪ Ten of the 10 (100%) submitted assessments documented oral hygiene recommendations. ▪ Ten of the 10 (100%) submitted assessments documented risk rating. ▪ Ten of the 10 (100%) submitted assessments documented community transition preparedness. ▪ Completion of the annual dental summary occurred within 19 days of the dental exam. Three occurred on the same day as the dental exam. It was noted that the Dental Department had begun to track (as of 6/6/13) the time between the annual dental assessment and the completion of the annual dental summary. Internal goals were established to have this time interval no more than 30 days, along with a review by a peer dentist within seven additional days. Additional information was included with the annual dental summary (as of 6/6/13), when applicable. This was a missed appointment log report for the individual. Of concern, the dental plan was present, but important aspects appeared at times to be scattered through the dental summary, and not located in one area. Additionally, it is suggested that the following be added or amended in the annual dental summary. It is important to note these are suggestions for a document that is already well written, and easily understood by a lay person, and are not requirements for compliance: ▪ The date of the last annual summary was not recorded on the document. ▪ The number of teeth probed in determining the range of pocket depth was not recorded. No	

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		periodontal chart was included to reference the number or location of teeth probed or location of findings. ▪ When summarizing the number of dental treatments performed, it was not clear the time span of those appointments (i.e., the prior year, prior six months, etc.) ▪ For transition to the community as well as dental treatment planning, a statement of when the next full mouth or bitewing x-rays were due was not documented. There was no odontogram visually documenting restorations, extractions, etc. <u>New Admissions</u> During the time period from 2/1/13 through 8/31/13, there were seven individuals admitted to CCSSLC. Seven of seven (100%) had completed an initial dental exam in the first month (from three to 16 days). <u>Oral Hygiene</u> An oral hygiene index was completed on each individual (that had teeth) at the time of the annual exam. The most recent oral hygiene scores were submitted for the entire campus, in a document entitled: "CCSSLC Current Oral Hygiene Ratings," dated 8/1/13. According to this document, for a census of 242 individuals, oral hygiene ratings from the most recent dental appointment indicated 117 (48%) had a good oral hygiene score, 72 (30%) had a fair oral hygiene score, and 53 (22%) had a poor oral hygiene score. This score included both individuals with teeth and those that were edentulous. All 19 edentulous individuals had good oral hygiene scores. To determine the oral hygiene ratings for those with teeth, these were removed. The population with teeth was 223. Ninety-eight (44%) had a good oral hygiene score. Seventy-two (32%) had a fair oral hygiene score, and 53 (24%) had a poor oral hygiene score. <u>Oral Hygiene Training</u> The number of new employees and number of employees terminating employment made it challenging to provide instruction in oral hygiene to the direct support professionals. From March 2013 through July 2013, there were 155 new employees. From March 2013 through June 2013, 133 employees left employment. From the documentation submitted, there were three types of training offered to employees. The new employee training was completed in lecture format (a PowerPoint of this presentation was submitted). A color-coded Dental Training CCSSLC roster was provided. Red indicated the employee no longer worked at CCSSLC. There were additional shades, which were not keyed. These were included in the tabulation as though they were current employees. The copy provided was in black in white, which created problems in interpretation. However, based on the keyed information provided, there were 531 employees identified needing dental training as of 8/9/13. Of these 463 (87%) received this training. Training rosters entitled: "Oral Hygiene Instructions: Educate new employees in basic oral hygiene instructions and knowledge of Dental Department procedures; staff will receive a handout about oral hygiene care for the home" were submitted for 9/7/12, 10/2/12,	

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		11/5/12, 12/6/12, 1/10/13, 2/22/13, 3/21/13, 4/22/13, 4/23/13, 5/17/13, 6/20/13, 7/24/13, 8/19/13, and 9/24/13. Annual refresher training occurred through an iLearn class through Staff Development. Hands-on training was completed in the Dental Clinic as well as in the residence. Training documentation in the Dental Clinic was provided through two systems. A document entitled: "CCSSLC Oral Hygiene Report (Clinic Chair-side Report – between 8/1/2012-7/31/13)" listed the names of the individuals and the accompanying direct support professional that were trained. Date of in-service for each encounter was documented. Some individuals and their staff received this training several times during the year. A total of 2277 encounters were listed. Additionally, staff signed training rosters for approximately seven daytime periods as they completed an in-service chair-side training in the Dental Clinic. These training documents were entitled "ABCs of Toothbrushing – Dental Clinic; Chair side education with direct care professionals and individuals." Dates of the submitted training rosters were 9/4/12 through 9/26/13. Each signature of staff included the date of the dental clinic training and the individual that the staff accompanied. This information could be verified in the "Clinic Chair-side Report." Additionally, a handout was submitted entitled "Chair-side," which listed five points concerning oral hygiene care as guidance to the direct support professionals. Training in the residence was tracked and recorded in the document: "DADTX Dental Training CCSSLC." Of the 531 employees, 369 (69%) had received hands-on training in the residential setting. Training rosters were submitted for this ("ABCs for individuals: re-educate staff in basic oral hygiene care with individuals at homes. Demonstrate tooth-brushing skills on models. Hands on demonstration with DCP staff and individual"*)*. Rosters were dated 6/14/13, 6/28/13, 7/7/13, 7/19/13, 8/9/13, and 8/23/13. These included each individual for which training occurred, and the staff in attendance signed in when participating in the hands-on demonstration. Training was focused on those individuals with prior oral hygiene ratings that were poor. There was a separate training roster for each individual for which training was provided to ensure that quality tooth brushing skills were demonstrated in those with poor oral hygiene ratings. Additionally, training rosters were provided for the time period 10/2/12 through 1/7/13 for hands-on training in the residence, and listed the employees provided hands-on training on the date of training. Training rosters for these sessions specific to individuals were not included (the training rosters per individual appeared to be an additional documentation step initiated 6/14/13). There were no residential hands-on training rosters provided between 1/7/13 and 6/14/13. Separately, the Dental Department tracked the training of individuals with dentition, in a database entitled "TBI (tooth-brushing instruction) given to individuals with dentition 8/1/12 through 7/31/13." Of the 241 individuals, 19 were edentulous. Of the 222 with dentition, 222 (100%) had tooth-brushing instruction.	

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		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 a residential exam/demonstration was conducted. The Dental Department provided a thorough training documentation system for these various training programs. <u>Suction Tooth Brushing</u> As part of preventive oral care, suction tooth brushing was provided to those with one or more of the following indications for this procedure: risk of aspiration pneumonia, are enterally fed, have a diagnosis of oral dysphagia or have a prognosis of poor oral hygiene (from working draft policy "CCSSLC – Dental Services: Suction toothbrush Usage"). A list submitted indicated 34 individuals received suction tooth brushing, which was 14 percent of the population. Four additional individuals were identified as potentially qualifying for suction tooth brushing. The Dental Department had scheduled these individuals for chlorhexidine gluconate trials with suction brush to determine appropriateness of suction tooth brushing for these individuals. The Dental Department had developed a policy for chlorhexidine use, entitled "Chlorhexidine with Suction Brush Protocol Q.21," and this was consistent with "Step 2" of the policy, which stated: "Prior to initiation of treatment, individual will be evaluated by dental staff to determine if he or she is able to tolerate the use of a suction apparatus without placing them at risk." <u>Individuals with Self Brushing Plans</u> Sixteen individuals had care plans/ISPs that included brushing one's own teeth independently without reminders or assistance. The oral hygiene scores of these 16 individuals were submitted for the prior two ratings completed at the time of the annual exam/prior one year. One individual was a new admission and had no prior oral hygiene score for comparison, leaving 15 for which two scores were provided. Thirteen remained in the same category of oral hygiene rating. There were 10 that maintained a good oral hygiene rating. For two, the individuals maintained a fair oral hygiene rating. For one, the individual continued to have poor oral hygiene ratings. For this individual, it was not identified 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 two individuals, the oral hygiene ratings worsened from good to fair. 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. An additional 31 individuals had care plans/ISPs that included brushing one's own teeth independently with reminders (i.e., could perform the task, but needed prompts to initiate the task). The oral hygiene scores of these 31 individuals were submitted for the prior two ratings completed at the time of the annual exam/prior one year. There was one new admission without a prior oral hygiene rating for comparison.	

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		Twenty-one remained in the same category of oral hygiene rating. There were 13 that maintained a good oral hygiene rating. For six, the individuals maintained a fair oral hygiene rating. For two, the individuals continued to have poor oral hygiene ratings. For these two individuals, it was not identified 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 three individuals that brushed their own teeth, there was improvement in the oral hygiene ratings from fair to good. For six individuals, the oral hygiene ratings worsened. For one individual, the rating changed from good to poor. For five individuals, the ratings changed from good to fair. 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 documented there was no flossing policy at the SSLCs. The Dental Department indicated there had been prior injuries such as torn papillae, lip laceration, cuts to fingers, and reduced blood circulation. The Dental Department listed 48 individuals that are flossed during dental procedures only. For one of these 48, staff assists the individual with flossing during the dental procedure. For these 48 individuals, flossing instructions was offered at the time of the dental visit and/or provided with varied response from refusal to selecting a preferred method (i.e., regular floss or floss picks). A list of those individuals with independent tooth brushing skills was provided, along with the reasons for those individuals not being able to floss independently or with assistance. For 16 individuals that brushed independently without reminders, none used floss. All were provided flossing instruction during the dental visit. The Facility's reasons for not allowing flossing independently have been mentioned in the prior paragraph. However, given that flossing is a recommended practice nation-wide, a more individualized approach should be used in determining which individuals can safely complete this task. <u>Pneumonia</u> The Facility submitted a list of those with a diagnosis of pneumonia from February 24, 2013 through July 12, 2013, along with the date of the dental appointment prior to the pneumonia, and the procedure completed during that appointment. Of a list of 21 individuals that had pneumonia, two individuals had a dental appointment within five days prior to the date of the pneumonia diagnosis. One individual had TIVA sedation during that appointment and had undergone an exam, full mouth debridement, and x-rays. The type of pneumonia was listed as bacterial pneumonia (not aspiration pneumonia). The other individual had a dental cleaning with limited fluoride treatment with no anesthesia, and developed bacterial pneumonia within two days.	

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Preventive, Restorative, Emergency Dental Services

The Dental Department provided the breadth of services required to care for the individuals at CCSSLC. From 2/1/13 through 8/31/13, 222 individuals (duplicate count) were seen for prophylactic care. From a document entitled: "Preventive Care Provided between 2/1/2013 - 8/31/13," generated 9/5/13, these visits occurred as prophylactic care only treatment or as a combination of other dental services (i.e., annual assessments, x-rays, topical fluoride treatment, etc.). The following was the breakdown per month of the number of prophylactic care treatments completed:

Month	Number of Prophylactic Care Treatments
February 2013	64
March 2013	47
April 2013	55
May 2013	27
June 2013	39
July 2013	53
August 2013	52
Total	**337**

From a document entitled: "Restorative Dental Work with Appointment Details between 2/1/2013 - 8/31/13," 17 individuals underwent restorative care during 20 appointments. The following was the number of restorations completed at each visit, along with the number of visits in which this occurred:

Number of Restorations per Visit	Number of Visits	Number of Restorations per Visit	Number of Visits
1	7	6	1
2	3	10	1
3	3	12	1
4	3	13	1

The following were the number of visits per month for restorations, and the total number of restorations completed per month:

Month	Number of Visits	Number of Restorations per Visit	Total Number Restorations for Month

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February 2013	2	1 to 10	11
March 2013	5	2 to 13	26
April 2013	5	1 to 4	8
May 2013	3	1 to 4	9
June 2013	1	3	3
July 2013	3	2 to 12	17
August 2013	1	1	1
Total	**20**		**75**

A total of 38 individuals were seen and treated for 41 dental emergencies.

Month	Number of Emergencies	Resolved	Month	Number of Emergencies	Resolved
February 2013	9	9	June 2013	4	4
March 2013	7	7	July 2013	5	5
April 2013	6	6	August 2013	4	4
May 2013	6	6	Total	41	41

From a document entitled "Extraction Report – all Practitioners" (report generated 9/5/13), 19 individuals underwent dental extractions. Nine individuals had this procedure by an oral surgeon. The number of teeth extracted per individual ranged from one to seven per visit. The following information provided the breakdown by visit and numbers of teeth extracted per visit:

Month 2013	Number of Visits with Extractions	1 Tooth Extracted	2 Teeth Extracted	3 Teeth Extracted	4 Teeth Extracted	5 to 7 Teeth Extracted
February	4	1	2	1	0	0
March	2	1	1	0	0	0
April	4	2	1	0	1	0
May	4	2	0	0	0	2
June	0	0	0	0	0	0
July	3	0	1	1	0	1
August	2	1	0	0	1	0
Total	**19 individuals**	**7 individuals**	**5 individuals**	**2 individuals**	**2 individuals**	**3 individuals**

From the document entitled: "Exams that were due in February 2013 [sic]," with run date of 9/9/13, 176 individuals were listed as having an annual dental exam last completed 2/1/12 through

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		10/2/12. The current annual exam dates of completion were listed for these individuals from 1/16/13 through 9/3/13. These annual exams were done as the only procedure, or were completed in combination with prophylactic treatment, x-rays, consultations, etc. The following number of annual exams were completed per month:	

Month	Number of Completed Annual Exams	Month	Number of Completed Annual Exams
January 2013	20	June 2013	21
February 2013	28	July 2013	19
March 2013	22	August 2013	17
April 2013	30	September 2013	2
May 2013	16	On Hold	1
Total = 176			

As noted with regard to Section I.1, concerns were identified with regard to dental supports for at-risk individuals. The following provide explanations of the concerns noted, particularly with regard to the development of plans to prevent further dental problems:

- The IRRF for Individual #95 indicated that this individual had 12 teeth pulled during the year. The individual had poor oral hygiene practices. There was noted anxiety with dental care, and assistance was needed in completing tooth brushing. The individual required TIVA during the year, had moderate periodontitis, and the oral hygiene rating was considered good. Despite the loss of teeth, moderate periodontitis, and lack of oral hygiene practices, the conclusion was that "current supports appear to be effective." This would need further explanation, as loss of multiple teeth was an undesired outcome and suggested the need to review supports provided to maintain oral hygiene, and an increased focus on dental hygiene for the IDT. There was no additional step such as increased monitoring of dental care to determine whether the needed assistance was provided, whether the direct support professionals needed additional training or support from the Dental Department, whether the assistance was resisted or accepted by the individual, a determination of steps including oral sedation to reduce the anxiety in visits to the dental office, etc. Twelve extractions and poor oral hygiene practices suggested the need for urgent, aggressive review of needed supports to reduce further tooth loss. The IRRF did not provide rationale for indicating "current supports appear to be effective."
- Individual #369 most recently had a poor oral hygiene rating. Examination under TIVA indicated severe periodontitis. This individual required annual TIVA exam and treatments. The individual had lost six teeth. A desensitization plan was in place, but there was little progress. It was known the individual did not like others brushing the teeth. The individual was to be prompted daily to brush teeth with an electric toothbrush. Despite the poor oral hygiene rating, severe periodontitis, lack of progress with desensitization, and resistance to

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		assistance with tooth brushing, the IRRF indicated that the "dental current supports appear to be effective." The rationale for this conclusion was not clear. Conversely, the supports in place, of which there were several, (i.e., TIVA, etc.) had not improved the individual's oral hygiene rating or severe periodontitis. For instance, with lack of progress with the desensitization plan, a review of this plan was indicated. There was no discussion whether further teaching and monitoring of direct support professionals had been done or was considered. There was no mention of preference for toothpaste flavor choice, or behavioral steps to motivate the individual to brush one's teeth. ▪ Individual #333 had two teeth extracted in 2/2013. The oral hygiene rating was considered good at that time and had declined to fair on 7/23/13. The individual had a total of 11 missing teeth. Despite the undesirable outcomes of further loss of teeth and worsening oral hygiene rating, the IRRF indicated "current supports appear to be effective" without further explanation. From the information provided, it appeared the dental status had declined, which would indicate need for further review. It was not clear how the current supports were considered effective, and further justification was needed for that statement. A comprehensive nursing review of 9/13/13 documented that "supports in place have proven partially effective." This may have been a more accurate statement. The IDT is encouraged to consider options to improve effectiveness of supports to minimize tooth loss and maintain and/or improve oral hygiene. <u>X-rays</u> The Dental Department referred to American Dental Association's "Recommendations for patient selection and limiting radiation exposure" in guiding the determination for ordering x-rays. The Dental Department listed 28 individuals that had an outstanding need for dental x-rays. The list was subdivided into categories prioritizing need, based on departmental guidelines. ▪ For Category A, there were 12 individuals listed. One had no record of a full mouth x-ray series, and the others had them in the past. Category A was defined as "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, limited dentition (number of teeth)." ▪ For Category B, there was one individual listed. This individual completed a full mouth x-ray series in the past, but was not current by professional standards. Category B was defined as "medium priority, oral hygiene fair/poor, combative, pending TIVA candidate, psychotic, irrational behavior, frequently refuses dental services, ability to cooperate present." ▪ For Category C, there was no individual listed. Category C was defined as "high priority, oral hygiene poor, decay present, mobility present, eminent need for dental restorations and/or extractions, new admissions." ▪ For Category O, 15 individuals were listed. Nine of the 15 had a full mouth x-ray series completed in the past. Six had no record of a full mouth x-ray series in the past. Category O was defined as "No ability to take x-rays, anatomy of the oral cavity, medically compromised, contraindicated for TIVA dentistry, fixation of the temporomandibular joint, fragile health,	

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		serious or terminal health condition, compromised airway." Additionally listed were seven new admissions. Of these, five had full mouth x-ray series completed in the first 30 days of admission. For two individuals, the x-rays were scheduled under TIVA (full mouth x-ray series) or through consultation with the oral surgeon (Panorex). The Dental Department appeared to be compliant with individuals who were newly admitted. Sufficient reasons for not undertaking full mouth x-rays for Category O appeared appropriate. There were no Category C individuals. For the one Category B individual, it appeared that an appointment had been obtained for TIVA. For Category A, there were 12 individuals for whom the perceived risk exceeded any immediate benefit, as it was a screening test for individuals without known disease. For compliance, it is essential the IDT documents agreement or no agreement, along with the guardian or family member of Category A individuals. Additionally a second opinion (written report) from a community dentist or oral surgeon would be helpful in confirming that risk outweighs benefits, or additional professional communication might lead to identification of community settings where the benefit would outweigh the risk. <u>Edentulous Individuals/Dentures</u> Information submitted in a document entitled: "Edentulous list" for the time period 2/1/3 through 7/31/13, indicated 19 individuals residing at CCSSLC were edentulous, for a rate of 19 out of 242 (8%). One individual became edentulous since the last onsite visit. According to a document entitled "CCSSLC Individuals who are edentulous with dentures between 2/1/13-7/31/13," there were no (0%) individuals who were edentulous with complete dentures. There were five individuals who were partially edentulous/mixed dentition, with upper or lower dentures. Reasons for individuals not having dentures (more than one reason was provided for some individuals) included: ▪ Nineteen - inadequate cooperation for denture fabrication to be completed; and ▪ Ten - complex oral anatomy (i.e., poor ridge formation, etc.). <u>Oral Sedation</u> Monitoring and evaluation of use of oral sedation was reviewed. Five active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ Three out of the five had orders for nothing by mouth (NPO) status or nothing per G-tube at the time of the dental visit. Two individuals were documented to not need NPO status. Three of three (100%) with NPO orders had confirmation the individual was NPO at the time of the dental visit. ▪ Five of five (100%) listed the medication administered, the dose, and the route. ▪ Five of five (100%) listed pre-procedure vital signs in the home. ▪ Five of five (100%) had an examination note/operative IPN/dental progress note (DPN) on the date of the visit.	

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Five of five (100%) documented pre-procedure vital signs at the dental office.
Two of five documented intra-procedure vital signs. For three individuals, the length of time for the dental appointment was brief and/or the individual was uncooperative.
Five of five (100%) documented post-procedure vital signs.
Adequate documentation regarding effectiveness of sedation was found in five of the five (100%) of the active records.
Five of five (100%) documented Dental Department follow-up (e.g., phone or visit) the next business day.
Five of five (100%) included documentation of current sedation consent from family/guardian/LAR.
Five of five (100%) included documentation of HRC review and approval.
Five of five (100%) included a completed restraint checklist.

The Dental Department had begun to track the notation of NPO status for those with pre-treatment sedation. Tracking began on 6/6/13.
<u>General Anesthesia/TIVA</u>
The Dental Department submitted the general anesthesia/TIVA appointment schedule for the time period 2/1/13 through 8/31/13. The number of appointments utilizing general anesthesia/TIVA completed per month were follows:
<table>
<tr><th>Month in 2013</th><th>Number of Completed Visits with General Anesthesia/TIVA</th><th>Number of Scheduled Visits With General Anesthesia/TIVA Not Completed</th></tr>
<tr><td>February</td><td>7</td><td>0</td></tr>
<tr><td>March</td><td>4</td><td>0</td></tr>
<tr><td>April</td><td>6</td><td>0</td></tr>
<tr><td>May</td><td>6</td><td>1</td></tr>
<tr><td>June</td><td>8</td><td>0</td></tr>
<tr><td>July</td><td>7</td><td>2</td></tr>
<tr><td>August</td><td>4</td><td>0</td></tr>
<tr><td>Total</td><td>42</td><td>3</td></tr>
</table>
As noted in the table, three individuals did not complete the initial general anesthesia/TIVA appointment. A follow-up appointment was completed under general anesthesia/TIVA for two of three cases. One follow-up remained pending for September 2013.
The active record was submitted for five individuals who had undergone general anesthesia/TIVA from 7/31/13 through 8/30/13. 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:
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</table>

#	Provision	Assessment of Status	Compliance
		annual dental exam, cleaning, x-rays, or restorative care. Review of these records revealed the following: ▪ Consent by the guardian/LAR for the dental procedures/anesthesia was current (i.e., defined as completed and dated within 365 days of the procedure) in five of five (100%). ▪ A copy of the HRC review and approval was submitted in five of five (100%). ▪ A dental IPN indicating the need for TIVA was submitted in five of five (100%). ▪ A pre-operative medical clearance was completed and submitted in five of five cases (100%). ▪ A pre-operative anesthesia record/clearance by anesthesia was completed and submitted in five of five (100%). ▪ Two of five cases required dental pre-treatment sedation. ▪ Pre-operative vital signs were recorded in five of five (100%) cases. ▪ An operative note by the dentist was recorded in five of five cases (100%). ▪ The operative anesthesia record was completed in five of five (100%). ▪ For those with teeth, a periodontal probing measurements/periodontal screening record was submitted for four of five. ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score, Aldrete Score, or other equivalent assessment was submitted in five of five (100%) of the active records. ▪ Post-operative vital signs were submitted in five of five (100%). ▪ A Dental Department post-operative follow-up note within one business day was submitted for five of five (100%). ▪ An annual dental assessment was completed while under general anesthesia/TIVA in five of five (100%) cases. The Facility provided information concerning injuries reported within 24 hours of general anesthesia/TIVA administration. For the time period February through July 2013, there were 38 completed appointments for individuals listed as having been scheduled for general anesthesia/TIVA, involving 38 individuals. Of the 38 appointments involving these individuals, there were no incidents of injuries (i.e., falls, etc.) in the following 24-hour time period. There were three individuals that developed an infection after TIVA. One individual developed a UTI after 24 hours. Two individuals were hospitalized. One developed urosepsis within 24 hours, and one developed bacterial pneumonia within five days. <u>Extractions</u> For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ From the submitted documentation, guardian/LAR consent was current in five of five (100%). ▪ HRC approval was submitted for four of five (80%). ▪ A dental IPN/DPN indicating the need for extractions was documented in five of five (100%), either completed pre-operatively or at the time of exam under general anesthesia/TIVA.	

#	Provision	Assessment of Status	Compliance
		▪ For four of the five cases, IV sedation/general anesthesia was used. For one of the five cases, oral sedation was used prior to IV sedation/general anesthesia. One had only a local anesthetic. One individual underwent IV sedation off campus. These descriptors are informational only. ▪ For the three cases undergoing TIVA sedation on campus, three of three received medical clearance (100%). ▪ For the three cases undergoing TIVA sedation on campus, three of three received anesthesia clearance (100%). ▪ From one to four teeth were extracted at a visit. This is informational only, ▪ The documentation submitted confirmed pain medication was provided in three of five cases. For one case using local anesthesia, need for pain medication was not clarified. ▪ A follow-up dental note the following morning in the Infirmary or a phone call to the residence (when not admitted overnight to the Infirmary) was documented in five of five cases (100%). ▪ A follow up visit was documented in five of five cases (100%) to determine healing or complications. <u>Off site oral surgery consults</u> For five individuals that underwent oral surgery consultation off campus, the dental record was submitted. The following findings were made: ▪ Two 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 procedure. ▪ One of five had a follow up post-op dental exam within 24 hours. Five of five (100%) had a post-op dental exam by the CCSSLC dentist to determine healing approximately one to two weeks after the oral surgery. ▪ Five of five (100%) included an oral surgery consult report. ▪ An anesthesia report (including medication and dosage administered) was submitted for five of five (100%). ▪ A copy of the current consent by the guardian/LAR was submitted for five of five (100%) of these oral surgeries. ▪ A copy of the HRC review and approval was submitted for four of five (80%) of these oral surgeries. <u>Emergency Treatment</u> Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: loose tooth, abrasion, oral ulcer, and benign lesion. The following findings are made based on this review: ▪ Five of five (100%) records documented the presence or not of pain. ▪ Pain was treated in three of three cases (100%).	

#	Provision	Assessment of Status	Compliance
		▪ Follow up was indicated for three cases. Follow-up occurred for three of three (100%) individuals. ▪ There was documentation of closure of the dental emergency (i.e., either no further visit required or scheduled for procedure/procedure completed) in five of five (100%) cases. ▪ The length of time from the notification of the dental emergency in the Dental Department to completing a visit varied from 0.25 hour to 6.25 hours. All initial dental visits occurred on the same day as notification of the emergency. 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 further refinement. 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 on educating individuals about flossing, but should continue its efforts to identify individuals who can and are willing to floss their teeth. For individuals with worsening oral hygiene scores, or who are otherwise at risk from a dental perspective (e.g., individuals that have had extractions or restorative work done), the Dental Department should work with IDTs to ensure aggressive supports are in place to improve their dental health. For some individuals, teams and guardians' review of decisions about x-rays were needed. 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	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 Interdisciplinary Teams, 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 developed and implemented since the Monitoring Team's last visit included the following: ▪ "Dental Services: Initial Dental Examination," revised 7/24/13; and ▪ "Dental Services: Annual Dental Examination," revised 7/25/13. The Dental Department had 40 policies in draft phase, which needed to be completed, approved, trained, and implemented. The Dental Department submitted a copy of the table of contents for the dental services manual. Certain dental services were not identified by the titles of the policy chapters in the table of contents. Areas which were not listed and are recommended as part of a comprehensive dental manual include the following areas as guidance to the Dental Departmental	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	staff: ▪ Dental emergencies (e.g., coverage, timely response); ▪ Tracking of periodontitis; ▪ Tracking of oral hygiene for those that independently brush their teeth; ▪ Dental Department post-op communication/follow up at 24 to 48 hours for dental procedures; ▪ Dental Department preparation, role, and follow-up as part of the IDT; ▪ Dental Department role in the morning medical meeting; and ▪ Routine maintenance and cleaning of dental equipment/dental x-ray equipment. If these areas are not included in other dental manual chapters, then inclusion in new chapters or as additions to current chapters is suggested. <u>Provision of Dental Records to IDTs</u> Copies of the most recent comprehensive exams from the active record were requested for one individual from each residence along with the copy from the dental office records. This was used to assist in determining whether the IDTs received adequate/complete dental information for the individuals. Documentation for 13 individuals was submitted and included dental progress notes, annual dental examinations, initial examination reports, annual dental summaries, periodontal charts, anesthesia records, post TIVA instructions, post TIVA orders, and individual sedation reports. One hundred thirty one documents were submitted. Two of these were interdepartmental emails, and were removed from the calculation. One hundred twenty nine documents remained. Of these, 129 were located in the dental section of the active record. One hundred twenty eight documents were located in the dental record at the dental office. This was a compliance rate of 99 percent. <u>Refusals/Missed Appointments</u> A review of information from a document entitled "List of refusals for the past six months per date of refusal" for the time period 2/1/13 through 8/31/13 indicated that 35 initial appointments were refused. Additionally, eight follow-up appointments scheduled to complete the initial appointments were refused. Twenty-eight individuals refused these 35 initial appointments or 43 initial and follow-up appointments. Thirty-one follow-up appointments were subsequently completed. Four follow-up appointments for these individuals were still pending/remained incomplete. Six individuals refused more than one appointment. Reasons for the scheduled initial appointments that were refused included: cleaning (11 appointments), cleaning/fluoride (three appointments), annual/cleaning/fluoride (one appointment), annual exam and cleaning (three appointments), annual exams (five appointments), emergency (one appointment), denture delivery (one appointment), desensitization (one appointment), TIVA procedure (two appointments), post-operative exam (one appointment), tooth brushing instruction and oral hygiene rating (one appointment), restoration and cleaning (one appointment), and restoration (four appointments). The refused appointments occurred from seven residences. Two residences had half of the	

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		individuals with dental appointment refusals. Residence #514 had nine individuals refusing dental appointments. Residence #522B had six individuals refusing dental appointments. **Month** / **Number of Refused Appointments** February 2013: 15 March 2013: 4 April 2013: 7 May 2013: 2 June 2013: 4 July 2013: 3 August 2013: 8 **Total: 43** For the 35 initial appointments that were refused, a follow-up appointment was completed in 31 cases. For 16 individuals, the completed appointments occurred from one to 15 days after the refused appointment. For eight individuals, the completed appointments occurred from 16 to 30 days after the refused appointment. For three individuals, the completed appointment occurred from 31 to 60 days after the refused appointment. For four individuals, the completed appointment occurred more than 60 days after the refused appointment. Four individuals had a refused appointment for which a completed appointment had not yet occurred by the time of the printing of the document. Separately, a document entitled: "Individuals identified to have refused dental treatment between 2/1/2013 -8/31/13" listed 28 individuals that had refused dental appointments. A "CCSSLC Dental Services Department monthly trending report" indicated that there were 41 individuals that refused treatment from February 1, 2013 through July 31, 2013. The reason for the discrepancy between documents was not determined. From the prior fiscal year of September 1, 2011 through August 31, 2012, there were 72 refused appointments, and in the most current fiscal year of September 1, 2012 through August 31, 2013, there were 83 refused appointments. <u>Non-refusals/Missed appointments</u> From an untitled document with run date 9/5/13, for the time period 2/1/13 through 8/31/13, there were 60 missed/no show appointments that were not categorized as refusals. Reasons for the scheduled appointments that were missed included cleaning (27 appointments), periodic/cleaning (one appointment), annual/cleaning (12 appointments), cleaning/fluoride (four appointments), periodic (one appointment), annual exam (three appointments), restorations (five appointments), TIVA (one appointment), and desensitization (six appointments). The missed/no show appointments occurred in 11 residences. The major reasons identified for missed appointments included: individual was ill (47), staffing issue in the home (three), conflict in the	

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		schedule such as off-site appointment or work (five), no consent (one), and behaviors (four). Two of the behaviors should have better categorized as refusals as the data entry indicated the "individual did not want to come" to the dental appointment. **Month** / **Number of Missed Appointments (Non-refusals)** February 2013: 23 March 2013: 19 April 2013: 5 May 2013: 1 June 2013: 1 July 2013: 3 August 2013: 8 **Total: 60** There were 46 initial appointments that were missed. Eleven individuals missed a follow-up appointment for completion, and one individual missed four follow-up appointments for completion. This was a total of 60 appointments that were missed. For the 46 original appointments that were missed, a follow-up appointment was documented in 40 cases. Six cases remained pending and four of these had appointments. ▪ For 10 individuals, the completed appointments occurred from one to 15 days after the missed appointment. ▪ For 16 individuals, the completed appointments occurred from 16 to 30 days after the missed appointment. ▪ For 11 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. From the document "CCSSLC Dental Services Department – monthly trending report," there was one missed/no show appointment other than due to refusal. There were additionally, 56 cancelled appointments. When comparing the last two fiscal years (September 1, 2011 through August 31, 2012, and September 1, 2012 through August 31, 2013), the missed appointments that were non-refusals decreased from 88 to seven, and the cancelled appointments reduced from 121 to 101. For the time periods of February 1 through August 31 for each fiscal year, there was a reduction in non-refusal missed appointments from 47 to one and there was a reduction in cancelled appointments from 62 to 56. It appeared the Dental Department made significant progress in reducing the missed appointments due to non-refusals, as well as impacted the number of cancellations.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
From the monthly trend report, the percentage attendance of appointments was tracked. For all appointments, the percentage attendance per month was as follows:
<table>
<tr><th>Month</th><th>Percent Attendance of All Appointments</th><th>Month</th><th>Percent Attendance of All Appointments</th></tr>
<tr><td>February 2013</td><td>135/175 = 77%</td><td>June 2013</td><td>113/122 = 93%</td></tr>
<tr><td>March 2013</td><td>85/107 = 79%</td><td>July 2013</td><td>117/125 = 94%</td></tr>
<tr><td>April 2013</td><td>91/102 = 89%</td><td>August 2013</td><td>105/121 = 87%</td></tr>
<tr><td>May 2013</td><td>72/76 = 95%</td><td></td><td></td></tr>
</table>
The overall percentage attendance at dental appointments from February 1, 2013 through August 31/2013 was 87 percent (718/828).

The Dental Department provided the steps/interventions taken when an individual had a refused/missed appointment. As of 6/6/13, the Dental Department began to reschedule missed appointments within 30 days (when openings became available). Previously, an appointment was rescheduled within 60 days.

CCSSLC generated daily reports that identified concerns that the Unit Morning Meeting attendees were responsible for addressing. This included a report from the Dental Department listing regarding missed appointments. This provided immediate information to the units concerning missed appointments. This was consistent with the CCSSLC policy “Quality Assurance E.6. Operationalizing Daily Data Reports,” implemented 12/5/10. The CCSSLC “Dental Appointments - Overnight Missed Appointments Report” included the name of the individual, the date of the missed appointment, the reason provided to the Dental Department, and the Unit and Home. The Unit review Team Morning Meeting then addressed this concern in the minutes under the sub-section “scheduled on campus medical and dental appointments,” which listed the type of appointment and whether the appointment was completed. If the missed appointment was due to a refusal, this information was additionally listed under the subsection “Refusals: Dental.”

The Dental Department communicated with each residence through a weekly email to report individuals that missed an appointment. It included the reason provided for the missed appointment, based on information provided to the Dental Department on the day of the appointment. There was a cover letter sent via email, which provided instructions that the QIDPs/IDTs needed to provide a written response to the Dental Department concerning the reason for the refused appointment and for action steps concerning the refused appointments. An attachment was sent with this cover letter, a document entitled “Missed Dental Appointments.” This categorized, in a chart format, the reason for the missed appointment: no show, refused, cancelled. There was an additional cancellation key listing eight factors contributing to the cancellation, and specifically identified those reasons for
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		which an ISPA was not required. Reasons for cancellations needing an ISPA were listed as: behaviors at home, staffing issues, scheduling conflicts (off campus appointments), furlough, and nursing issues. Reasons for not requiring ISPAs included dental issues, illness, and weather. The Dental Department also created a tracking database entitled "ISPA/Monthly Refusals Tracking Chart." For each refusal, there were three categories of tracking the response by the IDT: an ISPA or monthly review which addressed the refusal, an ISPA or monthly review which did not address the refusal, or an ISPA or monthly review which had not occurred. The categories were color coded for easy reference in determining the resolved refusals and those needing further IDT response. The submitted document listed the refusals per month from February 1, 2013 through September 13, 2013 Several ISPAs were submitted for missed appointments. For some IDT responses, the decision process did not address what caused a missed appointment, or if the concern was identified, did not address how this was to be resolved to avoid recurrence. The following appeared to have an inadequate response: ▪ Individual #238 had an ISPA, dated 6/21/13, for a missed appointment on 2/8/13 and 3/8/13 (refused). This was subsequently completed on 4/17/13. Although there was a successful appointment on 4/17/13, the ISPA did not indicate the steps taken for the 4/17/13 visit to ensure they would not be repeated at the next dental visit. There was no system in place to ensure the successful steps would be completed, and it was not clear how in a year or whenever the next appointment would occur, the IDT would recall the successful steps taken. There was no discussion concerning other options that were or were not successful in the past. ▪ Individual #61 missed an appointment due to a conflict of shopping. Although the team indicated that the dental appointments should not conflict with the individual's activities in the future, it was not clear how that would be accomplished (e.g., the communication to the Dental Department when a scheduled appointment would conflict with the individual's personal schedule, or who and how the Dental Department was to be notified when another event or appointment was taking priority). ▪ Individual #169 missed an appointment, but the ISPA of 4/15/13 indicated that staff would speak to the individual about maintaining health. It did not indicate what was specifically to be discussed, who was to do that, and how many times prior to the appointment. ▪ Individual #323 missed more than one dental appointment, and the reason was psychiatric concerns. There was no mention as to whether or not this was discussed with the psychiatrist, the recommendations from the psychiatrist, and the timeframe before compliance was expected. It was not clear how the Dental Department would learn when the individual's psychiatric health was stabilized to tolerate a dental visit. Due to the delusions of Individual #323, the option of a home visit and exam by the dentist and/or dental hygienist was not discussed.	

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		▪ Individual #158 missed a dental appointment. It was recorded that a PBSP was in place for program refusals, but it did not indicate whether the PBSP was followed or not, and if not, the need to review the PBSP if it was not a successful plan. ▪ For Individual #198, it was not indicated whether the psychiatrist was aware of the information provided on the ISPA, and whether the psychiatrist was aware the team determination that the medications were contributing to the missed appointment, along with a request by the IDT to review the psychiatry medications and pharmacy to review the entire medication regimen. The content of these ISPAs should be monitored to ensure the problem for which the IDT is to meet is addressed, and there is adequate documentation of the response and rationale. A Corrective Action Plan submitted by the Dental Department recorded similar findings on lack of response by the IDT to refused appointments. From a 6/6/13 entry, the Dental Department indicated "not all refusals are being addressed by the IDT during individuals' monthlys [sic]." This concern was discussed at the 6/6/13 QA/QI Council meeting. The Annual Dental Summary also listed missed/refused appointments, and cancellations. Although it was not stated in the summary, it appeared that the number reported was from the time period after the last annual exam to the present time. Also provided to the IDT was a copy of the Annual Dental Summary missed: no show/cancelled/refusal appointment log. This was a list of Dental Progress Notes on a single separate page that listed the date of the appointment, the time of the appointment, and the reason given to the Dental Department for the missed appointment. This included the name of the person in the home providing the information and the time the home was contacted for the information. As an ongoing QA tool to ensure each missed appointment was tracked to completion, the Dental Department created a table (untitled) to track the refusals and behaviors causing missed appointments to closure. This was tracked with the dental appointments, grouped by individual, to determine the number of appointments needed and reason, and when the individual successfully completed a dental appointment. This provided a timeline for each individual. There was a color key to determine those for which a follow up appointment was past 30 days (yellow) or past 60 days (orange). Further footnotes indicated TIVA dentistry was provided only two days each month, which determined the ability of some individuals to complete follow up in 30 or 60 days if they had an unsuccessful appointment without TIVA, and were being re-appointed with TIVA dentistry. Based on this review, the Dental Department had systems in place to identify missed appointments, notify the Units and IDTs about the missed appointments and the reasons for them, and reschedule appointments in a timely manner. The remaining issue was improving the quality of IDTs' responses to prevent to the extent possible future missed appointments.	

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Interventions to Minimize the Use of Sedating Medications and/or Restraints

Information was submitted concerning use of restraints for dental procedures. For the time period 2/1/2013 through 7/31/13, there were 826 completed appointments. The dental office **did not** use mechanical restraints. Fifteen of 826 (2%) of completed appointments utilized oral sedation. Forty-four of 826 (5%) completed appointments utilized general anesthesia/TIVA. The following table lists this information by month:

Month	Completed Appointments	Number of Appointments with TIVA/GA	Percent Appointments with TIVA/GA	Number of Appointments with Oral Sedation	Percent Appointments with Oral Sedation
February 2013	175	7	4%	3	2%
March 2013	107	5	5%	1	1%
April 2013	102	7	7%	2	2%
May 2013	75	6	8%	1	1%
June 2013	122	8	7%	3	2%
July 2013	124	7	6%	4	3%
August 2013	121	4	3%	1	1%
Total	826	44	5%	15	2%

Separately, a list of HRC-approved dental restraints was submitted, including the use of sedation (undated). A total of 127 individuals were listed that required dental sedation. Of these, 72 had HRC approval for general anesthesia/TIVA, 31 had approval for pre-treatment sedation, and four had approval for both pre-treatment sedation and general anesthesia/TIVA. Twenty had HRC approval for anesthesia/sedation administered through the oral surgeon's office/services. For eight individuals, there was no completed appointment date. For 119, the consent was current at the time of the dental appointment. Using a cut-off date of 9/1/13 for the submitted information, there were 30 of the 127 consents that appeared to be currently out-of-date. Compliance with current HRC approval was 76 percent (97/127). A current consent would no longer be needed if further pre-treatment sedation or TIVA/general anesthesia was not anticipated.

The Dental Department had developed a restraint and sedation tracking system. For each individual

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		with pre-treatment sedation and/or TIVA administration, information in this tracking system included the date of the sedation administration, the medication name and dosage, time of administration prior to the appointment, and effectiveness. This information was included in a report entitled "Dental Sedation Usage Report between 2/1/2013-7/31/2013." Additionally, the Dental Department developed an "Individual Sedation Report" which recorded the sedation provided dating back to 2010, which included this same information. This tracking of medication administration and effectiveness allowed the Dental Department to prescribe the minimally effective dosage of medication for successful dental visits. *Desensitization* A document entitled "Desensitization Tracking Table (Dental Desensitization Plan only)," with run date of 9/5/13, was submitted providing current information concerning desensitization and other behavioral programs to improve individual cooperation and compliance with dental visits. ▪ Ninety-six individuals had been identified as requiring desensitization or other plan to reduce the need for restraint. ▪ Thirty had completed a dental task analysis. ▪ Eight were undergoing task analysis or the task analysis had been completed, but the findings had not been finalized. ▪ Fifty-eight individuals were currently undergoing baseline dental trials. ▪ Of these, one dental desensitization plan had been developed based on the dental task analysis. Additionally, there were 25 dental desensitization plans that had been written from 2010 to 2012. ▪ There were 15 individuals that were edentulous that did not need dental desensitization. ▪ One hundred twenty eight individuals with teeth had been reviewed and did not meet the criteria for benefiting from desensitization or other plan to reduce the need for restraint. Thirty-eight of these had been identified in August 2013 due to a change in health status. One was considered not applicable in August 2013 based on an IDT meeting with ISPA documentation. Based on submitted information, several did not need sedation for routine appointments. ▪ One of one desensitization plan from 2013 had been implemented as of 7/23/13. Separately, a "Current Oral Hygiene Rating Report" was submitted that included whether each individual had a skill acquisition plan (SAP) or staff supported objective (SSO). The majority of individuals listed had either an SAP or SSO with date of implementation. For those without such a plan, no information was provided for the reason (i.e., not needed as the individual brushed their own teeth and has good oral hygiene ratings, edentulous, pending completion of plan, etc.). However, these SAPs and SSOs were in response to the Dental Department and IDTs' collaborative efforts to sustain good oral hygiene ratings and reverse those with declining scores. Separately, a "Current Oral Hygiene Rating – Poor" document was submitted that listed 46 individuals. Of these, 40 (87%) had SAPs or SSOs. This provided information specifically on the action steps taken for those with	

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		poor oral hygiene. The Dental Department submitted a form entitled "Tooth-brushing SAPs/SSOs Observation Form" to be completed when monitoring progress of the SAP or SSO. This was to have been implemented on 6/21/13. Data was to be located in the "Committee Minutes" according to the Action Plan, but the committee was not identified. The Desensitization Committee minutes were reviewed, and mentioned the need for monitoring of SAPs and SSOs, but data was not documented. It could not be determined whether monitoring of SAPs and SSOs had occurred. Action Step evidence in the Presentation Book for Section Q indicated there was no evidence of the IDT completing a monthly review of the desensitization activities. Details of the process were submitted. The dental task analysis consisted of 27 steps starting with the individual approaching the dental office. The roster of completed dental task analyses indicated the step at which the individual was to start. From a different chart, dated 8/17/13, entitled "Dental Clinic Baseline Trials Group," the Dental Department at that time was in the process of completing task analyses on 30 individuals. For six additional individuals, the task analysis had been completed. Twelve individuals were evaluated for task analysis, but were determined not to be candidates for desensitization. Eight individuals had been chosen for the next round of dental task analyses, but evaluation had not been started. It appeared the Dental Department accomplished this process by choosing small groups from six to nine individuals. Once the dental clinic baseline trials were completed, another group of six to nine individuals was chosen for review. For six groups, there had been completion of the baseline trials. The first group completed the baseline trials in February 2013. Additional groups completed the baseline trials in June through August 2013. Examples of the baseline "Dental Desensitization (rehearsal) steps" in the dental office were submitted. Separately, a document entitled "CCSSLC Individuals with Desensitization Plans/Desensitization Trials between 2/1/2013 and 8/31/13" documented 147 trials for 47 individuals. This list was similar to the prior Dental Department list of several groups of six to nine individuals. Each appointment date of the individual was listed, with the step (out of 27) and success indicated. It was noted that success was documented as "no" at all appointments, which needed further explanation/clarification as to whether the prior step had been successful. For some individuals, different steps were attempted over several visits, and with no success in any trial. The concern would be whether the plan was appropriate for the individual. Although the title indicated these individuals had desensitization plans, only 14 were listed as plans (all dated prior to 2013 and the current process), and the individual in the prior document with a developed and implemented plan was listed as not having a dental desensitization plan. One individual had an updated plan in 2012, but the more recent trials were for the older plan, and the earlier trials in 2013 were for the most recent plan. The data and process needed further review. The Action Plan evidence submitted in the Presentation Book Section Q indicated there was no evidence that the Dental and Psychology Departments had reviewed the desensitization plans quarterly for progress or stability of the plans. Separately, a document entitled "CCSSLC individuals with Desensitization Plans," with run date	

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		9/5/13, was submitted. This listed 31 individuals. However, this list did not agree with the Dental Department list. Five of the 31 were not considered candidates, three additional individuals were edentulous and only had medical desensitization plans, and for five individuals, the dates of the desensitization plans did not agree. A document was submitted entitled "Individuals Deemed Inappropriate for Dental Desensitization Plans per Behavioral Sciences," with run date 9/5/13. Forty-six individuals were listed. Reasons included: physiological (17), physiological – spasticity (16), psychological (one), edentulous (three), No sedation/no problems at dental/not afraid (nine). The number did not agree with the 128 listed by the Dental Department. The CCSSLC Desensitization and Pre-treatment Sedation Committee, an interdisciplinary team, followed the progress of the dental and medical desensitization process. Meetings were held 2/15/13, 3/25/13, 5/22/13, 5/28/13, 6/12/13, 6/20/13, 7/3/13, 8/13/13, and 8/14/13. The 2/15/13 minutes indicated direct support professionals' concerns about guidance for positioning during tooth brushing, as well as bleeding of the gingiva during tooth brushing, which was to be included in the SAPs. The 3/25/13 minutes indicated the committee would not be addressing "the use of pre-sedation [sic] for non-routine care such as mammograms, colonoscopies, gynecological care, and other related activities..." The 5/28/13 minutes documented the committee agreed to an operational definition for routine dental care/services as "simple cleanings, x-rays and scaling." The Committee agreed on the definition of non-routine dental care as "any procedure, which results in pain or requires any form of analgesic." It should be noted that these definitions had not been presented to the Monitoring Teams, and the Monitoring Teams had not expressed an opinion as to whether or not they were reasonable definitions. It also appeared that guidance of those that would benefit from an SAP was discussed and agreed upon, but the minutes were cut off and no further information was documented about criteria for SAP development. The 6/12/13 minutes documented that the psychology and dental desensitization databases did not have matching data. Problems with implementation of the desensitization plans also were identified. Concerns included not getting the individuals to the dental clinic, not completing trials in the residential setting, and not completing the desensitization data sheet. It was identified that the desensitization plans were not being included in the daily schedules of the individuals. Reference was made to two decision trees in guiding the IDTs in whether the individual was appropriate for a dental desensitization plan. The IDTs had referred individuals for a dental desensitization plan, but the individual needed a SAP or alternate plan. As a follow-up to this concern, the committee determined that a policy needed to be developed for the desensitization process. A determination of the person(s) responsible and due date back to the committee was not documented in the minutes. However, the Facility drafted a policy for "Protection from harm – restraints: desensitization process," dated 6/20/13, which reviewed basic components of identification of an individual benefiting from further intervention (i.e., SAP, SSO, desensitization plan, etc.), and the components of a desensitization plan. A "dental desensitization plan" generic format was drafted, along with a "dental desensitization data sheet" for documentation of progress.	

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In summary, although CCSSLC was continuing efforts to identify individuals in need of desensitization or other strategies to reduce the use of pre-treatment sedation to the extent possible, significant more work was needed in this area.

Internal Dental Department Quality Reviews

The Dental Department utilized 19 key indicators to monitor quality of dental care. However, most of them related to timeliness or presence of aspects of care, not necessarily the quality of dental care. These indicators were tracked on a monthly basis. Results were submitted for April through August 2013. The key indicators included the following:

1.	Number of annual dental exams scheduled
2.	Number of annual dental exams completed
3.	Number of annual dental exams completed within 365 days of previous annual
4.	Number of new patient exams completed within 30 days of admission
5.	Number of routine prophylactic exams scheduled
6.	Number of routine prophylactic exams completed
7.	Number of individuals with good oral hygiene
8.	Number of individuals with fair oral hygiene
9.	Number of individuals with poor oral hygiene
10.	Number of individuals/staff provided oral hygiene instructions
11.	Number of rescheduled appointments (dental cancellations)
12.	Number of emergency dental services required
13.	Number of emergency dental services evaluated within one business day
14.	Number of individuals receiving oral sedation
15.	Number of individuals receiving mechanical restraint
16.	Number of individuals receiving TIVA
17.	Number of individuals with dental desensitization plans
18.	Number of "no show" appointments
19.	Number of individual refusals

All data was available in a computerized database and appeared to be up-to-date. The database used Excel, PDF format or Word. Results for April through August 2013 were as follows, derived from submitted documents entitled: "CCSSLC Quality Indicators:"

Indicator	April 2013	May 2013	June 2013	July 2013	August 2013
1. Annual exams scheduled	28	33	21	17	17
2 Annual exams completed	28	33	21	17	16

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3. Annuals done in 365 days of prior	28	33	21	17	16
4. New admits - exams within 30 days	0	1	1	1	1
5. Prophylactic exams scheduled	61	29	42	52	52
6. Prophylactic exams completed	58	28	41	52	52
7. Individuals with good OHR	116	116	114	109	117
8. Individuals with fair OHR	77	78	79	72	76
9. Individuals with poor OHR	51	50	51	52	49
10. Individual/staff given OH training	84/70	56/51	67/67	82/92	73/75
11. Cancellations	4	3	2	3	7
12. Emergency services required	6	6	4	5	4
13. Emergencies seen in 1 business day	6	5	4	5	4
14. Receiving oral sedation	2	1	4	4	1
15. Receiving mechanical restraint	0	0	0	0	0
16. Receiving TIVA	6	7	8	7	4
17. Dental desensitization plan	34	34	25	31	31
18. "No show" appointments	0	1	0	0	0
19. Refused dental appointments	5	2	5	3	8

These reports were enhanced by "Dental Services Department – Monthly Trending Report." It provided information concerning dental attendance from FY 2010 through the month being reported. Additional graphs included the following information: attendance comparison (refused/no show/cancelled/came as scheduled), overall appointment attendance tracking (i.e., came as scheduled, total appointments, percent attended), shifts missing appointments, reasons appointments missed, appointment attendance by Unit, appointment attendance by home, types of services/procedures provided during the dental visit (from FY 2010 through the month being reported). Number of routine versus emergency appointments per month and quarter since FY 2010, oral hygiene ratings per month from FY 2010 through the month being reported, and oral hygiene rating as a percentile of the population on a monthly basis. These were in color and provided a visual tool from which trends could be identified.

The Dental Department also prepared a quarterly report for the QA/QI Quarterly Section Review of Settlement Agreement progress. This report included, in charts, graphs, and narrative format, a list of accomplishments, challenges the Dental Department faced, utilization of monitoring tools, analysis of monitoring results, review of corrective actions, status of pending policies and procedures, and departmental prioritization of tasks and challenges. From the minutes of the 4/26/13 QA/QI meeting, it was noted there were improvements in completing dental appointments, the oral hygiene rating had improved, and there was a reduction in poor oral hygiene from 32 percent to 15 percent from the 3rd quarter of FY 2011 to the 2nd quarter of FY 2013. According to the Facility's data, annual exams were completed in a timely manner. Challenges identified included the increase in refused appointments over the prior year. Despite the improvement over several quarters, it was noted that

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		there was a decline in oral hygiene ratings in the most recent quarter, due in part to reduced staff available for training. The desensitization program needed to meet the needs of the Dental Department. The 7/18/13 QA/QI Quarterly Section Review of Settlement Agreement progress indicated the Dental Department continued to have improved attendance rates. ISPAs for refused appointments began to be tracked. They were not being completed timely, and did not provide needed information. It was indicated that the new State database would eventually eliminate the current monitoring tools, but that it remained in a start up phase. However, as the monitoring tools reflected the dental services, it was not clear the rationale for eliminating these monitoring tools rather than incorporating them into the monitoring tool inventory. It was not clear how the new database was to capture the prior year's data in order to provide ongoing information concerning trends in dental services. The Dental Department also reported "QA Inter-rater monthly individual compliance from February through August 2013." From five to nine individuals were reviewed per month. The actual graphs did not indicate a comparison of scores by the QA Department and the Dental Department. "Compliance" across the months varied from 75 to 100 percent, but the Monitoring Team was not able to interpret this section of the internal, dental QA system, without the actual scores determined by the QA Department and the actual scores of the Dental Department on the same individual. It is recommended that further explanation and information be provided to allow the reader better understanding of these seven pages of data. The Dental Department submitted copies of printouts from databases used in the internal QI process, which provided information for the 19 indicators mentioned above, but also a number of other areas of dental services. These reports provided additional tracking and trending information for the Dental Department's self-assessment process. This provided evidence of the quality and completeness of the databases available to the Dental Department, and the collaboration between the Dental Department and the information technology support at CCSSLC. Copies/examples of the following databases were submitted: ▪ Annual assessments within 365.xls; ▪ New admission exams completed within 30 days form 2/1/3 through 7/31/13.xls; ▪ CCSLC – oral cancer screening conducted between 8/1/12-7/31/13; ▪ Review of chart records for treatment plans 8/1/12 through 7/31/13.xls; ▪ Untitled document summarizing oral hygiene ratings per month per unit and for the total campus (through July 2013); ▪ CCSSLC Current Oral Hygiene Ratings (dated 3/1/13); CCSSLC Current Oral Hygiene Ratings (dated 8/2/13); ▪ CCSSLC: Individuals without Dental Services within One Year (between 8/1/2012 to 7/31/13);	

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		▪ CCSSLC Oral Hygiene Report (Clinic Chair-side Report) between 8/1/12 to 7/31/13; ▪ Tooth brushing instruction given to individuals with dentition 8/1/12 through 7/31/13; ▪ Individuals Identified for Preventative Dental Care between 8/1/12 to 7/31/13; ▪ Dental Preventive Care 8/1/12 to 7/31/13.xls; ▪ Untitled emergency log tracked to closure 2/1/13 to 7/12/13; ▪ CCSSLC: Individuals who receive suction tooth brushing treatment between 2/1/13 to7/31/13; ▪ CCSSLC Extractions Reporting dates 2/1/13 to 8/19/13; ▪ Post dental extractions follow-up 2/8/13 to 8/6/13; ▪ Untitled Individuals with outstanding need for dental x-rays 8/1/12 to 7/31/13; ▪ DADTX Dental Training CCSSLC updated last 8/9/13; ▪ Untitled assessments required for ISP per month (August 2012 to July 2013); ▪ Sedation Report 2/1/13 to 7/31/13; ▪ For those undergoing TIVA, any incident of injury in 24 hours following TIVA administration in prior six months (time period 2/1/13 to 7/31/13); ▪ For those with documented pneumonia, for each individual, list date of pneumonia, date of last dental visit, type of procedure/visit and type of anesthesia given in the past six months (time period 2/1/13 to 7/31/13); ▪ HRC approval for pre-treatment sedation 2/1/13 to 7/31/13; ▪ Record review – NPO notation for TIVA 2/1/13 to 7/31/13; ▪ CCSSLC Dental Services Department – Monthly trending report; ▪ ISPA/Monthly Refusals tracking chart 2/1/13 to 7/31/13; ▪ Pre-treatment sedation Notation 2/1/13 to 7/31/13; ▪ Chart review – HRC approval for pre-treatment sedations 2/1/13 to 7/31/13; ▪ Chart review – HRC approval for TIVA 2/1/13 to 7/31/13; ▪ Chart review – NPO Notation for Pre-treatment sedations 2/1/13 to 7/31/13; ▪ Assessment Filing – Number of Times filed later than 10 days (2/1/13 to 7/31/13); ▪ CCSSLC Individuals with Desensitization Plans 8/21/13; and ▪ CCSSLC: Percentage of individuals utilizing oral sedation for dental exam and treatment between 2/1/13 – 8/31/13. These databases had current information, and members of the Dental Department could use them readily. Additional quality of care indicators were needed. The completeness and adequacy of the dental plans would benefit from monitoring for quality content and comprehensiveness. As a quality measure of dental care, tracking the rate of extractions/tooth loss (for non-traumatic reasons and excluding impacted wisdom teeth, etc.) each quarter, the rate of new caries in the quarter, or the number of individuals with new caries in the quarter, the number of individuals with gingivitis/periodontitis (none, mild, moderate, severe) per quarter, number of permanent fillings needing restoration replacement at 12 and 24 months are examples that would reflect quality of dental health. The Dental Department is encouraged to research clinical indicators that measure	

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		quality of care. This information might lead to ways for the IDTs to focus on additional steps to support good oral health in the residences.	

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 For 20 individuals (i.e., Individual #235, Individual #154, Individual #251, Individual #67, Individual #40, Individual #110, Individual #268, Individual #305, Individual #348, Individual #50, Individual #136, Individual #211, Individual #310, Individual #169, Individual #293, Individual #222, Individual #297, Individual #333, Individual #10, and Individual #349), 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, or monthly reviews by SLP; alternative and augmentative communication (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); 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; o Minutes for Speech Department meetings held since the Monitoring Team's last review;

	○ List of all general common area communication devices; ○ Blank communication competency-based performance check-off for individual-specific communication programs; ○ Completed audits of SLP documentation; ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since the Monitoring Team's last review; ○ Updated list of Individuals with Augmentative/Alternative Communication Devices, dated 10/4/13; ○ Updated list of Individuals with Personal Control Units, dated 10/4/13; ○ Updated list of Individuals with Communication Dictionaries, dated 10/4/13; ○ Past six months for swallowing/upgrading diet textures and results; and ○ Last six months of documentation of individuals trialed for AAC that have not been successful. ▪ **Interviews with:** ○ Dr. Angela Roberts, Director of Habilitation Therapy; ○ Nancee Dixon, Section R Lead; ○ Bryanna Gutierrez, SLP; ○ Melissa Grothe, SLP; and ○ Dora Barbosa, Speech Language Assistant (SLA). ▪ **Observations of:** ○ Individuals in residences and day programs.
	Facility Self-Assessment: Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 9/13/13. 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. ▪ Based on a review of the Facility Self-Assessment, as well as interview with the Lead SLP and the Director of HT, the following was found: ○ The monitoring/audit tools the Facility used to conduct its self-assessment included: the Settlement Agreement Monitoring Tool for Section R. The quarterly monitoring results were presented at the QA/QI Council meeting to facilitate integration amongst the different Plan of Improvement sections. In addition, multiple Facility-developed audit tools (i.e., PNMT assessment, PNMP) and HT database reports were implemented to assess compliance. ○ The data presented in the Self-Assessment reflected the completion of additional activities and audits, such as tracking attendance at PNMT meetings, review of PNMT referrals, PNMT assessment and PNMP audit tool, etc. ○ The monitoring tool and audits included adequate methodologies, such as observations, record review, and staff interview. ○ The Self-Assessment identified the sample sizes, including sample sizes adequate to consider them representative. ○ The Settlement Agreement Monitoring Tool for Section R had 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. However, the Facility-based audit tools (i.e., SLP assessment audit tool) did not have adequate instructions. o The following staff/positions were responsible for the Settlement Agreement Monitoring Tool for Section R: the Director of HT and PCM. The SLPs completed the Facility-based audit tools. 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, the HT Department database, NEO and annual refresher staff training databases, data related to ISPs, and Facility-based policies and guidelines. ▪ The Facility presented some data in a meaningful/useful way, but more work was needed. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured 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 Section R.1 and R.2. The Monitoring Team found the Facility in substantial compliance with Section R.2. However, the Monitoring Team did not find the Facility in compliance with Section R.1, because the Facility had not finalized a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC, and Facility policy/guidelines did not address the methods for tracking progress and documentation standards related to intervention plans. ▪ The Facility rated itself as not being in compliance with the Section R.3 and R.4. These findings were consistent with the Monitoring Team's findings. ▪ The Facility data identified areas in need of improvement. The Director of HT and the Facility PCM provided an analysis of the Section R Monitoring results that identified the potential causes for the issues with plans to ameliorate non-compliance findings.
	Summary of Monitor's Assessment: The Facility had three full-time SLPs, one full-time contract SLP, two part-time contract SLPs, and two Speech Language Assistants. The SLPs were licensed to practice in the state of Texas and were certified by the American Speech Language Association (ASHA). All of the SLPs had completed continuing education that related to communication and was transferrable to the population served. The Facility Lead SLP indicated that a time study had been initiated to assess SLPs' time commitment and workload related to the completion of assessments, the development and implementation of programs, provision of staff training, and monitoring implemented programs. The results of the time study had not been finalized. As a result, it remained unclear how the Facility had determined what an appropriate caseload would be for SLPs at CCSSLC, and the current caseload assignments far exceeded even the general rule that State Office had identified. All four individuals newly admitted to CCSSLC had communication assessments completed within 30 days. The Facility had made substantial progress with individuals' communication assessments. Individuals' SLP assessments within the sample included the majority of necessary elements.

	ISPs generally provided some description of individuals' communication skills. However, more work was needed to include communication goals and objectives into ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. Individuals who received direct SL therapy interventions had their plans initiated in a timely manner. However, monthly progress notes did not include necessary elements. Observations of individuals with AAC systems revealed individuals' systems were present and/or being used, were portable and functional, and staff were able to locate and discuss staff instructions. These observations were a substantial improvement over observations during the Monitoring Team's previous reviews. Competency performance check-offs had been developed and implemented for individuals' staff requiring individual-specific training on their AAC devices. In addition, staff instructions for these devices described how to maintain the devices (e.g., replacement of batteries). However, the Monitoring Team was not able to ascertain if all required staff had successfully completed individual-specific performance check-offs. The Facility had developed Communication Supports Monitoring Guidelines, effective 7/8/13. The monitoring guidelines stated that monitoring was done on equipment, and skill acquisition programs the Communication Services/Speech Pathology Department provided. Some important components were included, but the guidelines were missing the following elements: the process for identification, training, and validation for monitors, the process of establishing inter-rater reliability, and a process for data trend analysis and utilization of findings to drive training and problem resolution. The development and implementation of a Communication Monitoring Tool in late June 2013 was a positive development. The Facility Self-Assessment reported that data from this monitoring tool should be available during the Monitoring Team's next review. In addition, the Facility had been using the Monthly Person-Specific PNMP Check Sheet, but individuals with AAC systems had not been monitored on a consistent basis using this form.

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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	**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 #268, Individual #348, Individual #136, Individual #211, Individual #376, Individual #293, Individual #222, Individual #333, Individual #10, and Individual #349. ▪ **Sample R.2:** Four individuals receiving direct speech interventions including:	Noncompliance

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	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.	Individual #154, Individual #251, Individual #40, and Individual #268; ▪ **Sample R.3:** Eight individuals with a PBSP and communication deficits, including: Individual #251, Individual #305, Individual #348, Individual #136, Individual #211, Individual #310, Individual #376, and Individual #297; ▪ **Sample R.4**: Eight individuals with AAC devices including: Individual #235, Individual #154, Individual #251, Individual #67, Individual #110, Individual #268, Individual #348, and Individual #50. 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. **Staffing** The Facility had three full-time SLPs, one full-time contract SLP, one part-time contract SLP who provided 15 to 20 hours per week, and an additional contract SLP who provided 20 hours per week. One of the full-time SLPs was dedicated to the PNMT. There were two Speech Language Assistants who provided support to the SLPs. There were no SLP vacancies. In June 2013, one part-time contract SLP was assigned to develop criteria and upgrade individuals' AAC programs. The AAC Specialist worked with SLPs to develop individual-specific training and staff communication instructions. The Facility Lead SLP indicated that a time study had been initiated to assess SLPs' time commitments and workloads related to the completion of assessments, the development and implementation of programs, provision of staff training, and monitoring implemented programs. The results of the time study had not been finalized. Based on interview, the Speech Department had focused on catching up on SLP assessments. This focus on assessments had a positive impact, and is discussed in further detail with regard to Section R.2. The decision was made to split the caseload evenly and not assign SLPs to specific residences. Based on the current census of 241, with one SLP dedicated to the PNMT, the three remaining SLPs would have a caseload of 80 individuals. The Facility also had two additional part-time contract SLPs but these SLPs were not assigned a caseload. The Facility Self-Assessment stated: "information provided by the State Office stated an appropriate caseload for SLPs is 60 individuals to 1 SLP resulting in a 60-1 client to SLP ratio	

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		The Facility had not finalized a reasonable process to establish SLP caseloads, and the caseloads far exceeded the general rule State Office provided. The Facility should finalize the time study assessment to determine what an appropriate caseload would be for SLPs at CCSSLC. A "reasonable process" to determine an adequate number of SLPs should include an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities include, but are not limited to conducting assessments, participating in ISP and ISPA meetings, developing and implementing programs, providing staff training, and monitoring the implementation of programs. **Qualifications:** ▪ Six of six SLPs (100%) were licensed to practice in the state of Texas. ▪ Six of six SLPs (100%) had evidence of ASHA certification. **Continuing Education** Six of the six SLPs staff (100%) 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: ▪ Annual Habilitation Therapies Conference (9/20/12 to 9/21/12); ▪ Practical Activities for Milestone Development (11/8/12); ▪ NPO [nothing by mouth] Recommendations from the Modified Barium Swallow Study (MBSS) for Adults (1/26/13); ▪ Feeding Therapy: A Sensory Motor Approach (2/8/13); ▪ Texas Speech and Hearing Association Convention (3/7/13 to 3/9/13); ▪ Neurorehabilitation Conference 2013 (5/18/13); ▪ Denial of Deficits and Aphasia (1/19/13); ▪ Developing and Using Scripts in the Treatment of Aphasia (1/19/13); ▪ Designing Optimal Learning Environments for Children with Developmental Disabilities, Autism, or Other Behavior (12/29/12); ▪ Development of Symbolic Language in Children with Autism Spectrum Disorders (12/29/12); and ▪ Use of AAC Devices and Strategies for People with Aphasia (12/28/12). **Facility Policy** The Facility submitted the following policies: ▪ CCSSLC SLP Admission Guidelines, dated 7/31/13; ▪ CCSSLC SLP ISP Prep Communication Services Guidelines, dated 7/4/13; ▪ CCSSLC Communication Supports Monitoring Guideline, dated 7/8/13; ▪ CCSSLC Communication Services: Roles and General Responsibilities of Speech-	

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		Language Pathologists, R.1, revision date 11/19/12; ▪ CCSSLC Communication Services: Process for Servicing Individuals at High Risk (with Challenging Behaviors), R.2, revision dates of 1/31/13 and 4/2/13; ▪ CCSSLC Communication Services: Assessment, R.3, implementation date 11/19/12; and ▪ CCSSLC Communication Services: Referral Criteria, R.4, implementation date 11/20/12. The State and Facility policies included the following elements: ▪ Roles and responsibilities of the SLPs (meeting attendance, staff training etc.); ▪ Outline of the 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); ▪ A process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as problem resolution. The current policies did not address the following: ▪ Methods of tracking progress and documentation standards related to intervention plans. The monthly progress note should provide information beyond if the "the goal was met, not met, to continue or discontinue." The therapist (i.e., author of the plan of care) should provide a monthly progress note that summarizes whether the individual made progress with the stated goal, including a summary of the data that supports the finding (i.e., beyond the current check in a box with no summary of specific data from the trials conducted), whether or not the goal continues to support improved communication for the individual in their daily activities, the consistency of implementation, and recommendations for revisions to the communication intervention plan as indicated by the individual's progress or lack of progress (i.e., if an individual is not progressing, not participating, etc., a recommendation should be made for team review and modification, as appropriate). The monthly progress note should provide a summation of the individual's progress and/or	

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		lack of progress across the month, and not just list the individual sessions notes. It is important that the therapist share this information with the QIDP and IDT members. This process should be memorialized in policy. The Facility Self-Assessment noted an additional policy, CCSSLC Communication Services: Guidelines for Direct Speech Supports (i.e., R.5) that was to be presented at the next Policy review meeting. However, this policy was not provided to the Monitoring Team. The essential components of a monitoring policy are addressed with regard to Section R.4. In summary, the Facility had four SLPs and two part-time contract SLPs. However, the Facility had not finalized a reasonable process to determine what an appropriate caseload would be for SLPs at CCSSLC, and based on the allocations of caseloads, they far exceeded the general rule State Office provided. Six of the six SLPs had completed continuing education. The Facility SLP policies included all of the required elements with the exception of one element related to this section. The missing element was the methods for tracking progress and documentation standards related to intervention plans (i.e., other missing elements related to monitoring are discussed with regard to Section R.4. The Facility remained out of compliance with this subsection.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Assessment Plan** The Facility had a reasonable plan to assess individuals who would benefit from the use of alternative or augmentative communication systems. The Facility had defined the timeframe for the completion of communication assessments for individuals. Specifically, individuals' Communication Comprehensive Assessments were completed by 11/1/12. There was no waiting list for completion of SLP assessments. Based on policy, Assessments of Current Status were being completed prior to the individual's annual ISP meeting. **Communication Assessments Provided** Four of four individuals newly admitted since the last review (i.e., Individual #17, Individual #98, Individual #27, and Individual #33) (100%) received a communication assessment within 30 days of admission. For individuals newly admitted to the Facility, SLPs completed a comprehensive assessment and not a SLP screening. **Communication Assessment** The 10 SLP assessments reviewed for the individuals in Sample R.1 were current within the last 12 months. Five of the 10 assessments (i.e., Individual #211, Individual #376. Individual #293, Individual #333, and Individual #349) included all of the minimum	Substantial Compliance

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		basic elements. Four assessments were only missing one element (i.e., Individual #268, Individual #348, Individual #136, and Individual #222). This element was the discussion of monitoring findings. According to the Facility, these four individuals had AAC devices. The only element not completed for Individual #10 was that the assessment had not been completed at least 10 working days prior to the annual ISP. The Facility Self-Assessment reported that SLP assessment audits were initiated in February 2013. Self-audits were completed and/or audits were completed by a SLP that was not the assessment's author. In March, the SLPs identified problems in the auditing process. During weekly SLP Department meetings, discussions were held to determine if the problem was the audit tool, interpretation of the tool, and/or a problem for the writer of the assessments. Each audit tool error was discussed and the problem was resolved. It was reported that this process provided feedback to the SLPs and supported consistency in how the assessments were analyzed and audited. SLP assessment audits for 131 SLP assessments were completed from February to July 2013. Compliance scores were calculated for each of the 23 elements. Based on review of the individuals in Sample R.1, the following provides the details of the comprehensiveness of the communication assessments: ▪ Ten of 10 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Nine of 10 individuals' SL assessments (90%) were dated as completed at least 10 working days prior to the annual ISP. Individual #10's assessment was not; ▪ Ten of 10 individuals' SL assessments (100%) included diagnoses and relevance of impact on communication; ▪ Ten of 10 individuals' SL assessments (100%) 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; ▪ Ten of 10 individuals' SL assessments (100%) 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; ▪ Ten of 10 individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Ten of 10 individuals' SL assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels; ▪ Ten of 10 individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Ten of 10 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day	

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		program, home, work); ▪ Eight of eight individuals' SL assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. Individual #268 and Individuals #348 did not have a Communication Dictionary; ▪ Ten of 10 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. The SLP assessment discussed how an individual's current abilities could be enhanced; ▪ Ten of 10 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. The SLP assessment provided an analysis of the individual's current communication deficits with suggestions for direct interventions and/or skill acquisition programs; ▪ Six of 10 individuals' SL assessments (60%) 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. Four individuals in this sample had AAC devices as reported by the Facility. The results of Monthly Person-Specific PNMP Check Sheets were not reported (i.e., Individual #268, Individual #348, Individual #136, and Individual #222); ▪ Ten of the 10 individuals' SL assessments (100%) 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; ▪ Ten of 10 individuals' SL assessments (100%) offered a comparative analysis of health and functional status from the previous year. For these individuals, the SLP assessment provided an overview of an individual's health status over the past year. The therapist discussed the type of supports and services that had been implemented to minimize the impact on the individual's functional status; ▪ Ten of 10 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments. For these individuals, the SLP assessment provided an overview of the past assessment results with the current assessment data for communication function. The assessment analysis discussed if the individual's communication performance had remained the same, had improved, and/or had regressed; ▪ Ten of 10 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it; ▪ Ten of 10 individuals' SL assessment (100%) 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; ▪ Ten of the 10 individuals' SL assessments (100%) supplied a monitoring	

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		schedule. ▪ Ten of 10 individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. 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 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 needed were missing in the community; and ▪ Ten of the 10 individuals' SL assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. The SLP assessments provided 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: ▪ Eight of eight individuals' communication assessments and PBSPs reviewed (100%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ Eight of eight individuals' communication assessments (100%) contained evidence of review of the PBSP by the SLP. As noted in the Monitoring Team's last report, the Director of HT indicated that having SLPs attend Positive Behavior Support Committee meetings had not been productive. Since the last review, a SLP representative began attending BSC meetings with the goal of improving collaboration between SLPs and psychologists in the development of Positive Behavior Support Plans. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 4/10/13 to 7/31/13, participation by a SLP was noted in six of the 13 meetings (46%). In addition, 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 approach was providing a productive collaborative approach. A review of individuals' PBSPs in the sample showed the communication strategies were in alignment with the	

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		strategies identified in individuals' communication assessments. Based on this review of a sample of individuals, speech assessments were being conducted timely, and contained the necessary elements. In addition, the SLP Department had worked out an effective process to collaborate with the Behavioral Services staff on the development of BSPs and integration of speech and communication recommendations into BSPs. As a result, the Facility was found to be in substantial compliance with this subsection. To maintain compliance within this section, the Facility should take steps to ensure that the element that scored 60% during this review achieves a score of at least 90% by the next review.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Integration of Communication in the ISP** Based on review of the ISPs for eight individuals in Sample R.4, the following was noted: ▪ Eight of eight individuals had an ISP Preparation meeting. Six of these individuals' ISP Preparation meeting documentation indicated the attendance of a SLP and/or a designee (i.e., SLPA) was required. Four of the eight individuals' SLPs (50%) (i.e., Individual #154, Individual #251, Individual #110, and Individual #268) attended the annual ISP meeting. Three individuals' SLPs were required to attend the ISP, but SLPs were not present at the ISP (i.e., Individual #67, Individual #348, and Individual #50). ▪ Four of eight ISPs reviewed (50%) (i.e., Individual #251, Individual #235, Individual #268, and Individual #50) 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 staff could improve communication with the individual. The types of AAC and/or communication supports (including, but not limited to the Communication Dictionary and strategies for staff use) were identified. ▪ Four of eight ISPs reviewed (50%) (i.e., Individual #251, Individual #235, Individual #268, and Individual #50) 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. ▪ Seven of eight ISPs reviewed (88%) (i.e., Individual #110, Individual #67, Individual #54, Individual #251, Individual #235, Individual #268, and Individual #50) 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	Noncompliance

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		the use of the AAC system in multiple environments. ▪ None of eight 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** HT database reports, dated 10/4/13, identified the following: ▪ 19 individuals with AAC devices; ▪ 43 individuals with personal Environmental Control Units; and ▪ 71 individuals with Communication Dictionaries. Observations were conducted in the homes and/or day programs of five individuals (i.e., Individual #305, Individual #154, Individual #222, Individual #110, and Individual #268) with AAC systems in Sample R.4 and/or who had an AAC system. Findings included the following: ▪ Five of five observations (100%) found individuals' AAC devices present in each observed setting and readily available to the individual. ▪ AAC systems for five of five individuals (100%) were noted to be in use in each observed setting. ▪ AAC systems for five of five individuals (100%) were portable. ▪ AAC systems for five of the five individuals (100%) were functional. ▪ For five of five individuals (100%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices** The Facility maintained a List of General Common Area Devices, revised 8/14/13. The list identified the location, type and intent of the device and the date verified. The Facility Self-Assessment reported that during observations by Facility therapists prior to the Monitoring Team's review, generic AAC devices were missing staff instructions and staff and/or individuals were not utilizing these generic devices. The Facility noted that the use of generic AAC devices continued to be a "challenging area." The Monitoring Team agrees with these observations. During the review, the Monitoring Team and Facility SLPs and a SLPA observed the presence of general-use AAC devices during observations of individuals in their residences and workshops. However, the Monitoring Team did not observe communication partners and/or individuals engaging with these generic devices. **Direct Communication Interventions**	

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		Nine individuals were receiving direct speech therapy interventions. Sample R.2 initially included four of these individuals (i.e., Individual #154, Individual #40, Individual #251, and Individual #268). Individual #251 was not reviewed for all of the following indicators, because the SLP recommended direct therapy be discontinued. The IDT members accepted this recommendation. Review of these individuals' records found the following: ▪ Two of three individuals' direct intervention plans (i.e., Individual #268 and Individual #40) (67%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. ▪ For three of three individuals' records (i.e., Individual #40, Individual #154, Individual #268) (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. As noted above, Individual 251's SLP assessment, dated 7/30/13, recommended: "direct therapy is no longer recommended based on the fact the [Individual #251] refuses to participate and has a preference for using her verbal skills for communication." ▪ For none of three individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. ▪ For none of three individuals (0%), information was present regarding whether the individual showed progress with the stated goal on a monthly basis. ▪ For none of three 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 his/her daily activities. The Speech Therapy Weekly/Monthly Progress documentation provided a note for each therapy session. However, there were no monthly progress reports that summarized the benefit of the device and/or goal to the individual. ▪ For none of three individuals (0%), a report was found regarding the consistency of implementation. The direct therapy note included a section for the number of sessions attended, but in multiple progress reports the number of sessions attended was missing and/or inaccurate. Some of the documentation indicated the number of sessions attended and the total number of sessions for the month, but this was not consistent from month to month. ▪ For none of one individual (i.e., Individual #251) (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 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.	

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		Competency-Based Training and Performance Check-offs Competency-based training and performance check-offs for communication are addressed with regard to Section O.5 for new employees and veteran staff. **Individual-Specific Competency-Based Training** Six of the eight individuals' staff (i.e., Individual #50, Individual #110, Individual #268, Individual #154, Individual #251, and Individual #67) (75%) in Sample R.4 had received individual-specific training. However, the training documentation presented was not adequate to ascertain if all required staff had completed competency-based training and performance check-offs for these individuals' AAC devices. The individual-specific training documentation noted the SLP provided competency-based training and performance check-offs to the SLAs prior to the SLAs delivering training to other staff. The Monitoring Team requested individual-specific training documentation to identify the total number of staff (N) required to complete the training and the total number of staff (n) to have successfully completed individual-specific competency-based training and performance check-offs. To substantiate compliance with the provision of individual-specific training, the Facility will have to produce this training data. In summary, observations of individuals with AAC devices were excellent. All necessary AAC elements were present for these individuals. This was a substantial improvement over observations that have been conducted during past reviews. ISPs generally provided some description of individuals' communication skills. However, more work was needed to incorporate communication goals and objectives in ISPs, as appropriate, and/or integrate communication strategies into other goals and objectives. For individuals learning to use AAC devices or receiving direct therapy, goals or objectives also needed to be developed and included in ISPs to structure skill acquisition, and provide a mechanism to measure progress. For individuals receiving direct therapy, two of the three individuals' plans were implemented in 30 days. The SLP assessments provided a rationale for direct therapy. Additional work will need to be done for individuals receiving direct therapy interventions with monthly progress notes. Speech Therapy Monthly Progress Reports for individuals provided a note for each individual session. However, there was not a sufficient monthly summary note (i.e., information regarding whether the individual showed progress with the stated goal on a monthly basis, and a description of the benefit of the device and/or goal to the individual). Individual-specific training and performance check-offs had been developed and implemented for some of the individuals in the sample. However, it could not be determined if all the required staff had successfully completed the competency-based training and performance check-offs. The Facility remained out of compliance with this section.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Monitoring System** The following policies, procedures and/or guidelines were submitted: ▪ CCSSLC Communication Supports Monitoring Guidelines, dated 7/8/12. The State policy and Facility's guidelines included the following elements 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); and ▪ The frequency of monitoring for individuals within the established Master Communication Plan priority levels. The Facility did not have a Master Communication Plan but the guidelines did address the frequency of monitoring for individuals with AAC devices. The Facility Communication Services Guidelines did not address the following elements: ▪ The process for identification, training, and validation for monitors; ▪ The process of establishing inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). **Monitoring of Implementation of Communication Supports** The Facility used three monitoring forms for communication: ▪ Monthly Person-Specific PNMP Check Sheet, revised on 5/8/13; ▪ Communication Monitoring form, which was a new monitoring form and was implemented 6/24/13; and ▪ Augmentative/Alternative Communication Data Collection Form, dated 6/25/13. PNMP Coordinators were responsible for completing the Monthly Person-Specific PNMP Check Sheet. This form monitored communication devices, communication dictionaries, and hearing devices. These devices were monitored for presence, use of the device, and the condition. Since the last review, this form had been revised to expand the description for the condition of the device (i.e., good, fair, and poor). The Monthly Person-Specific PNMP Check Sheet had instructions for its completion. These instructions were comprehensive. Results from completed monitoring forms were entered into the HT Department database. SLPs and SLAs used the Communication Monitoring form. SLAs were not completing this	Noncompliance

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		form independent of the SLP. On 6/23/12, the SLPs provided training on the form to SLAs. This form monitored the operational use of the device, including presence, working order, proper placement, staff instructions available, use, and condition. In addition, there were indicators for social interactions, strategies for implementation, and effectiveness of the AAC device. The Communication Monitoring form had instruction for completion, effective 6/24/13. The instructions for this tool were adequate. The Facility Self-Assessment reported that data from this monitoring tool should be available during the Monitoring Team's next review. SLPs and SLAs used the AAC Data Collection form. Written instructions were in the process of being developed. Monthly Person-Specific PNMP Check Sheet and Communication Monitoring forms were reviewed for individuals in Sample R.4 and the following was found: ▪ The Monitoring Team requested documentation of AAC equipment (i.e., Monthly Person-Specific PNMP Check Sheet) monitoring for the past three months. Five of the eight individuals with AAC systems (i.e., Individual #251, Individual #50, Individual #154, Individual #268, and Individual #110) (63%) had been monitored. Only two of these eight individuals (25%) had been monitored on a monthly basis (Individual #251, and Individual #50). The remaining three individuals (i.e., Individual #154, Individual #268, and Individual #110) had only been monitored one time across the three-month period. Individual #235 and Individual #348's records indicated: "no AAC equipment monitoring forms required," although the Facility listed these individuals as having AAC devices. The Monthly Person-Specific PNMP Check Sheet had not been implemented on a monthly basis. ▪ Communication Monitoring forms were requested for three months. Seven of the eight individuals' staff (i.e., Individual #235, Individual #110, Individual #50, Individual #154, Individual #67, Individual #268, and Individual #251) had been monitored. Two of the eight individuals' (25%) (i.e., Individual #110 and Individual #67) staff were monitored for each of the three months. Three of the eight individuals (i.e., Individual #50, Individual #268, and Individual #235) had been monitored for two months. Two individuals (i.e., Individual #251 and Individual #154) had been monitored for one month only. Communication Monitoring forms had not been completed per established frequency. The Facility reported that data reports from this new monitoring process would be available during the Monitoring Team's next review. In summary, the development and implementation of a Communication Monitoring Tool in late June 2013 was a positive development. The Facility Self-Assessment reported that	

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		data from this monitoring tool should be available during the Monitoring Team's next review. This form provided additional information to allow SLPs to analyze the effectiveness of individuals' AAC devices. Individuals with AAC systems had not been monitored on a consistent basis using the Monthly Person-Specific PNMP Check Sheet. The Facility remained out of compliance with this subsection.	

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 Listing of individuals with most recent ISP meeting, date ISP completed, date ISP filed, and previous ISP date, from 8/1/12 to 7/31/13 (TX-CC-1309-I.4); 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 #238, Individual #138, Individual #137, Individual #19, Individual #40, Individual #318, Individual #98, Individual #93, Individual #118, Individual #371, Individual #198, and Individual #368; o For Section S.1, Dental and/or Medical Desensitization Plans, as available, for: Individual #147, Individual #285, Individual #31, Individual #58, Individual #4, Individual #19, Individual #9, Individual #211, Individual #198, Individual #87, and Individual #363; o For Section S.1, Dental Desensitization Plan for Individual #83; o Facility Engagement Report, February 2013 to July 2013; o 5-minute Engagement Tool, revised 9/30/13; o For Section S.2, Preferences and Strengths Inventory (PSI), Functional Skills Assessment (FSA), Individual Support Plan (ISP), pre-ISP Addendums, as available, for: Individual #238, Individual #138, Individual #137, Individual #19, Individual #40, Individual #318, Individual #98, Individual #93, Individual #118, Individual #371, Individual #198, and Individual #368; o For Section S.2, Vocational Assessments, as available, for: Individual #238, Individual #138, Individual #137, Individual #19, Individual #40, Individual #318, Individual #98, Individual #93, Individual #118, Individual #371, Individual #198, and Individual #368; o Summary of Integrity Checklists for Skill Acquisition Plans, February 2013 to July 2013; o Community Integration Report, February 2013 to July 2013; and o For Section S.3, Skill Acquisition Plans, SAP raw data (for August and September 2013) and Monthly Integrated Progress Notes (for July and August 2013), as provided, for: Individual #238, Individual #138, Individual #137, Individual #19, Individual #40, Individual #318, Individual #98, Individual #93, Individual #118, Individual #371, Individual #198, and Individual #368. ▪ **Interviews and Meetings with**: o Section F review with Rachel Martinez, on 10/1/13; o Section S review with Kimberly Benedict, on 10/1/13 and 10/2/13; o Meeting with QA/QI and Section S Program Compliance Monitors, including Kimberly Benedict, Day Program Director, and Araceli Matehala, Program Compliance Monitor, on 10/2/13; o Phone conversation with Judy Sutton, M.S., LPC, BCBA, on 10/9/13; and o Phone conversation with Kristina Sheets, Director of Residential Programming, on

	10/9/13. ▪ **Observations Conducted**: o Observation and discussion at the Restraint Reduction Committee meeting, on 9/30/13; o Observation and discussion at the Vocational Career Fair, on 9/30/13; o Observation and discussion at the Skill Acquisition Committee meeting, on 10/1/13; o Observation and discussion at the Desensitization Committee meeting, on 10/2/13; o Observation and discussion at the Restrictive Practices Committee, on 10/2/13; o Onsite direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or afternoon hours at the following residential and day programming, and habilitation sites: ▪ Apartment 522B (Kingfish 2), on 9/30/13 and 10/3/13; ▪ Apartment 522 C (Kingfish 3), on 9/30/13; ▪ Apartment 522D (Kingfish 4), on 9/30/13; ▪ Apartment 524D (Ribbonfish 4), on 10/1/13; ▪ Apartment 524B (Ribbonfish 2), on 10/1/13; ▪ Apartment 524A (Ribbonfish 1), on 10/1/13; ▪ Apartment 524C (Ribbonfish 3), on 10/1/13; ▪ Horizons, on 10/3/13; ▪ Kaleidoscope, on 10/3/13; ▪ Apartment 522A (Kingfish 1), on 10/3/13; and ▪ Apartment 514 (Dolphin), on 10/3/13.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S, dated 9/13/13. 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. Summary data of compliance ratings as well as inter-rater reliability scores based on Section S program monitoring tools from February through and July 2013 were provided. Verbal reports indicated that this process included the comprehensive review by three independent raters who completed two monitoring tools per month. Compliance and inter-rater reliability scores were provided on the Section S Self-Assessment and examples of completed rubrics (for four individuals) were provided for June and July 2013. It should be noted that ratings were missing from multiple raters for June 2013 with regard to the provided documentation. 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. According to verbal reports, 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. Currently, data reported within the Self-Assessment reflected average monthly compliance ratings ranging from 0% to 32% (between February and July 2013) and average monthly inter-rater reliability estimates ranging from 59% to 100% (between February and July 2013). Discussions during the onsite visit reflected a very collaborative and effective monitoring process. Reports indicated that this monitoring had not changed since the Monitoring Team's last visit. ▪ Used other relevant data sources: o The current Self-Assessment also contained other types of data from other available sources. This included data obtained from sampled skill acquisition plan rubrics, engagement tools, integrity checklists, SAPs, including dental and medical desensitization plans, and Individual Support Plans. In addition, data was obtained from the review of sampled assessments, including educational and training assessments, functional skills assessments, preference and strengths inventories, vocational assessments, and situational assessments. Lastly, data from the database used to track community outings, classroom and vocational attendance, and employment/employer data was utilized as well. ▪ 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 subsections of Section S. This was consistent with the Monitoring Team's current findings.
	Summary of Monitor's Assessment: Continued effort and progress was noted with regard to the skill acquisition plans format, including dental desensitization plans. Although some improvement was noted in developed SAPs, concerns regarding their overall quality remained. The level of engagement the Monitoring Team estimated was less than expected given previous estimates. In addition, lower than expected rates in the completion of engagement estimates by the Facility was concerning. However, changes in the method of collecting engagement data appeared promising. The ongoing collection and dissemination of attendance data appeared likely to facilitate improved work and program attendance. Progress was noted in the systems that support the adequate completion of assessments that examine individuals' preferences, strengths, skills, needs, and barriers to community integration. However, as related changes take time to occur, concerns regarding the adequacy and/or timeliness of sampled assessments (e.g., PSI and FSA) remained. Progress was noted with regard to the number of individuals experiencing situational assessments and/or vocational explorations. Progress was noted with regard to monitoring skill acquisition through the use of Monthly Reviews. One related highlight was the initiation of the Program Review Committee. In addition, efforts to improve the

	systems used to review skill programs, train competent trainers, and ensure adequate data collection were noted. However, the Facility will need to ensure adequate opportunities for skill acquisition in the community.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Continued effort and progress within habilitation training and services was noted, including improvement in the formats of skill acquisition plans, including dental desensitization plans. However, concerns regarding the quality of SAPs remained. Currently, in an effort to review the adequacy of the most recently developed SAPs, a sample of 12 individuals with ISP meetings since the Monitoring Team's last review. In an attempt to ensure a representative sample across residential programs, one or more individuals who met this criterion were selected from each residential program with the exception of the Sea Horse residence. More specifically, the sample included individuals from 10 of the 11 residential programs based on the provided summary listing of most recent ISP dates (i.e., TX-CC-1309-I.4). According to this documentation, approximately 77 individuals had ISP meetings during the last six months. Consequently, the current sample reflected approximately 16% of those individuals. Overall, a total of 57 SAPs provided for these 12 individuals were briefly reviewed, and it was found that each individual had approximately five (range of two to eight) SAPs implemented at the current time. It was noted that, of the 12 individuals reviewed, 12 (100%) had at least one SAP targeting completion in a community setting, 11 (92%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings (the exception was Individual #98), and 12 (100%) had at least one SAP targeting completion in the home. 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 are identified below: ▪ The SAP for Individual #238 targeting community awareness (ISP dated 8/13/13); ▪ The SAP for Individual #138 targeting diet texture (ISP dated 6/13/13); ▪ The SAP for Individual #137 targeting choice making (ISP dated 5/28/13); ▪ The SAP for Individual #19 targeting feeding animals (ISP dated 6/26/13); ▪ The SAP for Individual #40 targeting money management (ISP dated 4/19/13); ▪ The SAP for Individual #318 targeting vocational skills (ISP dated 6/4/13); ▪ The SAP for Individual #98 targeting stress management (ISP dated 5/21/13); ▪ The SAP for Individual #93 targeting family contact (ISP dated 5/1/13); ▪ The SAP for Individual #118 targeting emotion identification (ISP dated 5/2/13);	Noncompliance

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		▪ The SAP for Individual #371 targeting sensory awareness (ISP dated 5/24/13); ▪ The SAP for Individual #198 targeting choice making (ISP dated 5/14/13); and ▪ The SAP for Individual #368 targeting exercising (ISP dated 5/31/13). Of the 12 SAPs reviewed, the following was noted: ▪ Zero (0%) had adequate behavioral objectives. That is, all of the behavioral objectives were missing an adequately, operationally defined behavior(s) and/or clear criteria or standards for determining when the objective had been accomplished. For example, many of the objectives still referenced a certain specific step of the task analysis in parentheses within the objective (e.g., Individual #371, Individual #98, and Individual #40). In addition, many used criteria that was too stringent (i.e., a required 100% on a single trial per month for Individual #198, Individual #371, and Individual #19); ▪ Four (33%) had adequate operationally defined target behaviors. These included Individual #19, Individual #318, Individual #93, and Individual #368; ▪ Four (33%) had an adequate task analysis. These included Individual #19, Individual #318, Individual #93, and Individual #368; ▪ Twelve (100%) appeared to have an adequate description of the setting/environment; ▪ Ten (83%) appeared to have adequate information on necessary materials. The information provided for Individual #137 and Individual #371 appeared somewhat vague; ▪ Eleven (92%) had an adequate description of the schedule of implementation. The SAP for Individual #318 was relatively vague (i.e., the individual's work schedule was unknown); ▪ Nine (75%) had sufficient opportunities for learning to occur. Those SAPs with insufficient or unclear information about learning trials included Individual #238, Individual #19, Individual #318, and Individual #371; ▪ Twelve (100%) described relevant discriminative stimuli. It was good to see the use of non-verbal discriminative stimuli in some of the SAPs reviewed; ▪ Twelve (100%) contained adequate descriptions/definitions of the types of prompts within the listed prompt hierarchy; ▪ Twelve (100%) conspicuously identified the type of chaining (i.e., forward chaining) utilized in the SAP. However, concerns were noted regarding the lack mastery criteria (i.e., when to change steps); ▪ Twelve (100%) identified the instructional strategy (e.g., least-to-most); ▪ Twelve (100%) described specific consequences for correct responding. However, most (67%) of the SAPs identified multiple prompt levels that would be accepted as a correct response. It was unclear why specific multiple prompt levels were included; ▪ Twelve (100%) adequately described specific consequence for incorrect	

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		responding. However, concerns were noted as described below; ▪ Twelve (100%) identified the use of reinforcers following correct responding. It appeared that the majority (83%) included both verbal praise as well as other preferred, more concrete primary and conditioned reinforcers; ▪ Zero (0%) described mastery criteria for moving onto another step within the task analysis; ▪ Although all (100%) of the SAPs used forward chaining, zero (0%) had instructions on when to increase (or decrease) prompt levels. That is, mastery criteria for moving to a less intrusive prompt level was not described; ▪ Twelve (100%) identified plans for generalization and maintenance; and ▪ Eleven (92%) contained adequate documentation instructions. The exception was the SAP for Individual #371 that prescribed weekly data collection on a skill taught monthly. Provided documentation evidenced ongoing efforts by the Facility directed at revising the SAP format. More specifically, revisions initiated in July 2013 targeted the stated rationale (i.e., including how reinforcers were identified), the elimination of references to individual steps in the behavioral objective, emphasis on more detailed operational definitions, conspicuous identification of the instructional methodology, elimination of unnecessary prompts, and more detail regarding ongoing monitoring and change criteria. More recent revisions, initiated in August 2013, appeared to target the integration of recommendations from the speech assessment as well as continued delineation of prompting types. Review of sampled SAPs, as described above, found variable adherence with regard to these new revisions. For example, 100% of the reviewed SAPs included specific descriptions related to identified reinforcers, maintenance and generalization methodology, conspicuous identification of forward chaining, and specification of the task analysis step on the data sheet. However, less than 25% of those sampled adhered to the identification of speech recommendations within the rationale, removal of the specific task analysis step from the objective, separation of independent from other prompt levels, and the prescribed statement regarding oversight. Lastly, although all the SAPs had standardized language regarding staff responses to correct and incorrect responding, adequate mastery criteria was not included in any of the SAPs. Overall, it appeared that revisions were underway and that comprehensive revision will take time. Overall, the reviewed SAPs appeared relatively consistent with those reviewed in the Monitoring Team's previous report. However, slight improvements were noted concurrent with revisions as described above. It is expected that SAPs will continue to improve as the Facility adheres to recent changes within the SAP format. As reported above, the current examination revealed inadequacies within all of the sampled SAPs	

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		and, consequently, they continued to not meet the requirements of the Settlement Agreement. As previously noted with regard to Section C.4 of the Settlement Agreement, based on provided summary documentation ("Desensitization Plans," TX-CC-1309-PH3), it appeared that approximately 14 individuals were identified as having a medical and/or dental desensitization plan currently in place at the time of the Monitoring Team's visit. More specifically, according to provided summary documentation, 14 individuals were identified as having a desensitization plan implemented on August 1, 2013. A closer inspection of a sample of those plans, provided as part of the pre-visit documentation request, indicated that 11 (100%) were updated on August 1, 2013. That is, the initial implementation dates (e.g., "date started" or "date begun") listed on the plans revealed that 10 (91%) were initially developed and implemented sometime in 2012. The exception was the plan for Individual #363 (i.e., the recorded "date begun" date was 3/1/13). Consequently, all but one of these plans appeared to be written nine to 12 months earlier and were only just recently updated. It should be noted that, based on a brief review of these plans, the Monitoring Team could not determine the specific content that was updated other than perhaps the date listed within the objective. In general, inadequacies in these plans were consistent with those noted in the Monitoring Team's previous reports. For example, the plans appeared to lack individualization as well as other critical elements, including the lack of measurable objectives, inadequate task analyses, omission of prompting hierarchy and related mastery criterion, error correction procedures, emphasis on differential reinforcement, and 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. Overall, although recently updated (in August 2013), all of these plans were completed using the same format previously reviewed and, consequently, remained similarly inadequate compared to those plans previously reviewed. As previously noted with regard to Section C.4 of the Settlement Agreement, based on provided documentation, it appeared that the Facility had developed a new format for dental desensitization plans (Section C.4.9 of the Presentation Book). More specifically, although not dated, the form appeared to reflect a recent change in format and required content, including the inclusion of several critical elements that were missing from the previous desensitization plans. According to the Section C Action Plan, specifically section C.4.9, the development of this draft format began in June 2013 and was scheduled for completion in December 2013. Consequently, this new format appeared to be the basis for four new plans developed in the last few months. More specifically, as noted with regard to Section C.4 of the Settlement Agreement, four desensitization plans appeared to be developed using the new format. This included plans for Individual #83, Individual #119, Individual #67, and Individual #273. However, as previously noted,	

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		only one dental desensitization plan (i.e., for Individual #83) was available for the Monitoring Team's review. Based on the verbal report of the Director of Day Programming, new desensitization plans will be written in this new format by one of the Behavioral Health Services Provider and Active Treatment staff will monitor ongoing performance. Currently, review of the available dental desensitization plan for Individual #83 revealed a significant improvement compared to previously reviewed plans. More specifically, the plan included measureable behavioral objectives, a rationale, an operational definition, a specific prompt sequence, a specific task analysis, and maintenance and generalization strategies. However, the plan was limited by the excessive number of objectives (i.e., seven objectives), lack of specification within the objective (i.e., the term "prompt" was unclear), the omission of an identified teaching methodology (e.g., it appeared to be forward chaining, but this was not specified), lack of specification regarding mastery criteria (i.e., when to change steps), and lack of specification with regard to how prompt levels are documented. Nonetheless, despite these limitations, the plan appeared improved. However, given that only four of these new plans had been developed, it continued to be unlikely that the majority of desensitization programs were adequate. Verbal reports indicated that initial efforts at implementing this new format had targeted only dental desensitization plans. That is, medical desensitization plans had not yet been developed using this new format. Overall, as noted above, 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. 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. It should be noted that fewer engagement estimates were completed during the current onsite visit compared to the Monitoring Team's previous reviews. 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.	

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		Engagement Observations *Location* / *Engaged* / *Staff-to-individual ratio* 522B: 4:6 / 1:6 522C: 4:4 / 3:4 522D: 7:7 / 3:7 524D: 1:5 / 0:5 524B: 3:11 / 2:11 524B: 2:4 / 2:4 524A: 1:11 / 1:11 524A: 0:4 / 0:4 524C: 5:9 / 4:9 522A: 1:1 / 2:1 Overall engagement was 45%. An engagement level of at least 75% would be a typical target for a facility like CCSSLC. Compared to the estimate of engagement reported in the Monitoring Team's previous report, the current finding reflected a decline in the estimated level of engagement. It appeared that the strained staff-to-individual ratios observed in several of the programs likely negatively impacted observed engagement levels. However, this estimate should be cautiously interpreted as the current estimate was based on fewer actual engagement probes compared to the Monitoring Team's previous visits. According to verbal reports and provided summary documentation (i.e., "Facility Engagement Report," dated February to July 2013), the Facility continued to actively monitor engagement across the Facility. More specifically, the 5-Minute Engagement Tool continued to be utilized to estimate engagement within all residential and day program sites. According to the Director of Day Programs, active treatment supervisors were still expected to complete two engagement tools per site each week. These estimates were then collected and reviewed monthly. Currently, summary data provided continued to reflect the number of engagement tools completed each month between February and July 2013 across residential and day programs. In addition, estimated engagement based on these completed tools was also available. Based on the data provided, it appeared that the number of tools completed each month across residential programs ranged from three to 12 per month. This reflected a completion rate, based on the expectation of two engagement probes completed each week for a total of eight engagement probes completed each month (in each residential program), of 84%, 81%, and 80% for programs within the Atlantic, Pacific, and Coral Sea units, respectively. This reflected an increase in the percentage of	

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		engagement probes completed for Pacific and Coral Sea units compared with those reported in the Monitoring Team's previous report. However, it should be noted that less than 80% of expected probes were conducted in 50% of the residential programs. With regard to day programs, given the expectation that two engagement tools were collected each week (for a total of eight per month), it appeared that 23%, 98%, 50%, 90%, and 19% of the expected engagement tools were completed during this time period in the Annex, Vocational, Outer Reef, Horizons, and Kaleidoscope programs, respectively. Reports indicated that these lower than expected rates were likely due to the fact that three Active Treatment Supervisors were out on leave for four months during this time period. The Facility also reported monthly engagement estimates across each program as well as overall engagement estimates for residential as well as day programs. In general, the Facility reported overall residential and day program engagement estimates of 86% and 98%, respectively. Closer examination of the data revealed that the Facility reported engagement rates at or above 75% for each residential and day program with the exception of below expected performance (less than 75%) for Dolphin (in February and April 2013), Porpoise (in April 2013), and Kingfish 2 (in April 2013). This reflected a decrease in estimated engagement rates for these programs compared to those reported in the Monitoring Team's previous report. According to summary documentation, these inadequate engagement estimates initiated corrective action plans that reportedly improved subsequent engagement at these residential programs. More specifically, it appeared that four corrective action plans were implemented and engagement rates estimates following the completion of the plans were reported to have improved. Review of these corrective action plans revealed that they targeted the purchasing of items to support active treatment, involved staff training on active treatment, engagement, and zoning, including active treatment staff, leadership staff (i.e., residential coordinators, team- and assistant-team leaders) and direct support professionals. The Facility also reported overall engagement estimates for each day program site of at or above 92%. However, it should be noted that, although the Facility suggested that this estimate was "… an accurate snapshot …," this estimate was based on the completion of approximately only 56% of the total number of engagement probes expected to be completed during this time period (i.e., two per week at each program). Consistent with previously reported findings, it appeared that a recent ICF facility survey once again found deficiencies in engagement at residential programs. This repeated finding in conjunction with the Monitoring Team's findings suggested that 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 continued to over-estimate levels of engagement. Current discussion with the Director of Day Programs revealed active efforts to revise the 5-minute	

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		engagement tool to address the continual inflation of engagement estimates. More specifically, revision of the tool included removal of all passive engagement indices. Consequently, the rubric would only include items targeting the implementation of informal or formal active treatment, including the completion of skill acquisition programming. The Monitoring Team reviewed the revised 5-minute Engagement Tool (dated 9/30/13) and found reference to passive engagement removed from the tool as well as the addition of items specifically targeting evidence of skill acquisition programming, attempts to get everyone engaged, observation of parallel talk, and evidence that a current activity schedule was in place and being followed. The Monitoring Team found these changes to be promising and perhaps more likely to accurately estimate levels of individual engagement. Currently, the system prescribed the use of a partial-interval system across multiple individuals. Given the Facility's concern regarding accuracy of engagement estimates, the Facility might experiment with other methods of measurement (e.g., momentary time sampling) to determine which method is most efficient while providing the most accurate estimate of engagement. Typically, when staff members become aware that they are being observed, their behavior changes, including often increases in efforts to engage individuals. Momentary time sampling could help to control for this reactivity effect. As noted in the Monitoring Team's previous report, the Facility appeared to collect and monitor data on work refusals and/or percentage of time individuals attended day or vocational programming. At that time, it was reported that percentage classroom attendance (from September 2012 through January 2013) was 69%, 84%, and 26% for Atlantic, Coral Sea, and Pacific, respectively. In addition, data indicated that percentage vocational attendance (from September 2012 through January 2013) was 63%, 24%, and 28% for Atlantic, Coral Sea, and Pacific, respectively. It was unclear why similar data was not provided to the Monitoring Team for this review. That is, although verbal reports indicated that this system remained in place and that ongoing attendance continued to be monitored, more recent data, similar to the data described above, was not provided by the Facility as expected. However, other evidence appeared to reflect the use of this data to improve attendance. For example, the Facility appeared to more closely examine the nature of attendance issues for 10 individuals with the lowest work attendance and 30 individuals with the lowest class attendance. More specifically, as reported in Section S.3.a of the Facility's Self-Assessment, ISPAs for these individuals were reviewed to determine if changes were made to address each individual's refusals and potential need for additional services. Results indicated that IDTs had made programmatic changes for only 30% and 27% of the individuals with the lowest work and classroom attendance, respectively. The Director of Day Programs reported an additional effort to improve attendance through increased awareness. The Director of Day Programs indicated that this information was now more accessible to teams, because attendance data was now expected to be included within monthly reports. As reported in Section S.3.a below, rates	

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		of attendance to work, class and/or program sites were reported in most of the sampled Monthly Reviews. Reportedly, this increased awareness would likely improve attendance rates for many individuals. Lastly, verbal reports indicated that the availability of a new para-transit bus had improved attendance to work and programming for many individuals, including individuals living at Ribbonfish. The Monitoring Team's previous reports have been somewhat critical with regard to the limited opportunities for individuals to work off campus in competitive employment positions. As noted in the Monitoring Team's last report, approximately 15 individuals were working in community-based sites, including 13 individuals in off-campus enclaves and two individuals in off-campus competitive employment positions. This did not include one individual who was currently working in an on-campus competitive employment position. According to summary data listed within the Vocational Services Department Report (2/1/3 through 7/3/13) as well as data reported within the Section S Self-Assessment, it appeared the number of individuals employed within on-campus client worker programs and on-campus workshops remained relatively consistent. However, during the same time period, the number of individuals working in the community, either through supported employment, enclave settings, or competitive employment, gradually declined from 22 to 18. The Facility reported that this decline was primarily related to individuals who were successfully employed while living at the Facility and who have now moved into community residential programs. Lastly, reports indicated that at least eight individuals had transitioned from campus-based to community-based vocational positions between February and July 2013. Overall, the most recent data reported (July 2013) revealed that 119 (49%) individuals were currently supported through vocational programs, including 101 individuals employed on campus and 18 employed off campus. The Monitoring Team has consistently noted the Facility's various attempts to develop new vocational, day, and other programs in an effort to support individuals in a variety of capacities off their residential programs. In the past, these efforts included computer and exercise classes as well as a retirement program and individualized programming for individuals with Autism. Efforts to develop off-campus opportunities also was noted as the Facility worked to develop connections with community-based employers to increase the number of off-campus positions as well as the contracts available for on-campus vocational positions. As noted in the Monitoring Team's last report, marketing materials (e.g., pamphlet and DVD) were developed, and a new gift shop (open February 14th) and a coffee shop (opened March 2013) were opened. Currently, emphasis had been placed on having the Marketing and Job Developer facilitate six community contacts per month (increased from four per month), as well as continued participation in recent job fairs, community fundraisers, and local job expo (attended by six community-based companies and 130 residents). These efforts demonstrated some success, as a new community	

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		work site and recycling pick-up sites had been added since the Monitoring Team's last visit. Data reported in the Facility Self-Assessment indicated that 34 community-based work-site contacts were finalized (from February to July 2013), which resulted in two new settings supporting employment for individuals. Due to the continued inadequacy as noted with the development of SAPs, including in the areas of dental and medical desensitization, and with continued inadequate engagement across programs, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue ongoing efforts to ensure the development of adequate SAPs, as well as promote and monitor acceptable levels of engagement across all programs.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Progress was noted in the system that supports the adequate completion of assessments that examine individuals' preferences, strengths, skills, needs, and barriers to community integration. However, as noted below, as related changes take time to occur, concerns regarding the adequacy and/or timeliness of sampled assessments remained. As described in the Monitoring Team's previous reports, the Preferences and Strengths Inventory was now 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, out of the 12 individuals sampled, only five (42%) PSIs were current, adequately completed, and available prior to the ISP Preparation meeting. Currently, in an attempt to estimate the current use of the PSI with regard to informing the ISP process, a sample of 12 individuals who had ISPs completed since the Monitoring Team's last visit was selected. This was the same sample as described previously (with regard to Section S.1 of the Settlement Agreement) and reflected approximately 16% of those individuals with ISP meetings held over this time period. Currently, of the 12 individuals sampled, 12 (100%) PSIs were dated within the last 12 months. Of these, however, only eight (67%) 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 #19, Individual #98, Individual #93, and Individual #371 were completed (dated) after the date of the ISP Preparation team meeting (as evidenced by ISP Preparation addendums dated 6/10/13, 5/21/13, 4/21/13, and 10/3/13, respectively). In addition, 10 (83%) of the PSIs were completed prior to the actual ISP meeting. More specifically, two PSIs were completed after the actual ISP meeting. This included the PSIs for Individual #98 and Individual #371.	Noncompliance

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		Regardless of the completion date, of the 12 PSIs reviewed, only seven (58%) appeared to be adequately completed. That is, one or more sections were not fully completed (i.e., for Individual #238, Individual #138, Individual #371, and Individual #198), content within the summary and/or analysis sections appeared cryptic or vague (i.e., for Individual #238 and Individual #371), and/or the PSI was not signed and/or dated (i.e., for Individual #138 and Individual #368). Overall, out of the 12 individuals sampled, it appeared that only four (33%) of their PSIs were current, adequately completed (including author name and date), and available prior to the ISP Preparation meeting. This was consistent with previous findings noted in the Monitoring Team's last report. Since the Monitoring Team's last visit, the Facility appeared to address previous inadequacies as noted within the completed PSIs through in-service training provided for QIDPs (dated 6/19/13). Based on the current review, it appeared that more training is necessary. It should be noted that the Monitoring Team acknowledges the high turnover in QIDPs since the Monitoring Team's last visit. Consequently, current inadequacies in this review (as described above) might be related more to staff turnover than ineffective training. The Monitoring Team's previous report noted revisions to the format and content of the Functional Skills Assessment including additional information within the FSA Recommendations section, including areas for information on identified preferences, strengths, needs, goals, barriers to community integration, supports needed to overcome barriers, skill training recommendations, and ideas for the future. At the time of the last review, approximately 42% of the FSAs sampled were completed using this new format. However, many of these appeared to contain vague recommendations and provided insufficient summary of identified needs. Overall, it appeared that only 25% of the FSAs sampled last time were adequately completed using the new format. In an attempt to examine the current use and status of the FSA, a sample of 12 individuals who had ISPs completed since the Monitoring Team's last visit was selected and their most recently completed FSAs were reviewed. This sample was the same one as described above and utilized in relation to Section S.1 of the Settlement Agreement. Currently, of the individuals sampled, 12 (100%) had FSAs completed within the last 12 months. Of these, 12 (100%) FSAs had been completed prior to the ISP meeting and 11 (92%) included the use of the new FSA recommendations section. The exception was the FSA for Individual #19 that was missing this last section of the assessment. Consequently, it was unknown if the section was missing or had not been completed. Similarly, a page was missing from this section of the FSA for Individual #318. Indeed, of the 12 FSAs reviewed, only 10 (83%) appeared to be fully completed. However, concerns were noted with regard to the adequacy of several sections of the FSA. That is, several sections appeared somewhat incomplete compared to other content found within the assessment. For example, most of the FSAs sampled appeared to have insufficient	

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		description and summary of identified needs related to living, working and leisure (i.e., Individual #138, Individual #137, Individual #40, Individual #318, Individual #118, Individual #371, Individual #198, and Individual #368). In addition, many FSAs sampled appeared to have insufficient specificity with regard to skill training recommendations (i.e., Individual #137, Individual #19, Individual #318, Individual #98, Individual #371, and Individual #198). Lastly, it appeared that informants were reluctant to provide ideas for the future for individuals within the sample (i.e., Individual #238, Individual #137, Individual #371, and Individual #198). Overall, out of the 12 individuals sampled, it appeared that only seven (58%) of the FSAs were adequately completed. Indeed, two did not evidence completion of the new recommendations format (i.e., Individual #19 and Individual #318) and three had multiple sections that appeared inadequate (i.e., Individual #137, Individual #371, and Individual #198). In general, it was still unclear to the Monitoring Team how this assessment facilitated the prioritization of identified needs and related goals. Nonetheless, the current finding does reflect a slight improvement compared to the Monitoring Team's previous findings. However, it should be noted, that current deficits were similar to those previously identified as well. According to provided summary data (Vocational Assessment Completed 2/2013 to 7/2013), it appeared that approximately 74 vocational assessments were completed since the Monitoring Team's last review. In an attempt to examine the adequacy of current vocational assessments, 12 individuals who had ISPs completed since the Monitoring Team's last visit was selected and their most recently completed vocational assessments were reviewed. This sample was the same one as described above and utilized in relation to Section S.1 of the Settlement Agreement. This sample of vocational assessment reflected approximately 16% of those completed since April 2013. Of the 12 vocational assessments provided for review: ▪ 12 (100%) were either completed or updated within the past 12 months; ▪ 12 (100%) were completed prior to the ISP meeting; ▪ Three (25%) were "updated," and as a result, did not contain the same content as the other, more comprehensive assessments (as discussed below in more detail). These included the vocational assessments for Individual #137, Individual #93, and Individual #198; ▪ 12 (100%) included a vocational vision or the IDT's best guess (i.e., for individuals that did not communicate verbally); ▪ 12 (100%) included recommendations regarding current vocational skills; Because the three "updated" assessments (i.e., Individual #137, Individual #93, and Individual #198) did not include the same level of current content, they were not included in the following analysis. Consequently, of the nine completed vocational assessment: ▪ Nine (100%) included information on preferences, work history (if applicable),	

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		strengths, barriers and necessary supports related to work. However, the necessary supports listed appeared quite vague for three of the individuals (i.e., Individual #238, Individual #138, and Individual #318); ▪ Nine (100%) included ideas for the future. However, only seven (78%) included ideas for the future that were specifically related to work; ▪ Six (67%) included the content regarding integration of services, including prioritized preferences, strengths, and tentative goals (across living, relationship, employment, leisure, independence, etc.). The exceptions included Individual #40, Individual #98, and Individual #118. It appeared that these three assessments were completed using an older format (i.e., March 2012 instead of January 2013); ▪ Eight (89%) listed one or more situational assessments completed within the last two years. This included seven and three assessments that identified one or more completed on- and off-campus situational assessments, respectively. The exception was Individual #368. ▪ Four (44%) listed one or more vocational explorations completed within the last two years. This included one and three assessments that identified one or more completed on- and off-campus vocational explorations, respectively. These included the assessments for Individual #40, Individual #318, Individual #118, and Individual #368. ▪ Of the nine individuals with completed situational assessments and/or vocational explorations, it appeared that eight (89%) were consistent with the identified vision (or the IDT's best guess). Overall, review of sampled vocational assessments reflected improvement in the number of individuals experiencing situational assessments and/or vocational explorations. In addition, it appeared that more individuals had a vocational vision identified within their assessments, even if the vision was the IDT's educated guess, compared to the previous review. However, the majority of identified visions continued to appear limited to what was available on campus and/or based on the current job the individual held. Consequently, continued emphasis should be placed on the completion of community-based situational assessments or perhaps more novel on-campus 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 or vocational explorations, including a greater diversity of experiences potentially available in community-based off-campus 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 State Office Discipline Coordinators recently developed a new standardized format for all assessments, with a few exceptions. This new format,	

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		scheduled to rollout in October 2013, included the vocational assessment. A brief review of the revised vocational assessment revealed a more comprehensive and detailed format that appeared likely to facilitate the integration and summary of information from the current assessment with information from other sources (e.g., from the PSI or ISP preparation meeting). The Monitoring Team looks forward to reviewing this new format at the next review. Since the Monitoring Team's last review, the Facility reported the development of a new committee, entitled the Program Review Committee, which was designed to provide a peer review process for ISPs and monthly reviews. This committee was initiated in July 2013, and had begun actively reviewing ISP documentation. This review included the use of a developed rubric to examine the quality of monthly reviews. Based on the current review of sampled monthly reviews (as described with regard to Section S.3.a below), this process appeared to be very helpful in improving the quality of monthly reviews. Due to the continued inadequacy and concerns as noted above, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility continue ongoing efforts to ensure the development of adequate assessments (e.g., PSIs and FSAs) through critical review (during the Program Review Committee), including the use of quality rubrics and ongoing training of new QIDPs.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Some progress was noted with regard to monitoring the monthly performance of individuals through the use of Monthly Reviews. However, concerns remained regarding the development of quality SAPs, including their procedural integrity. It should be noted that the Facility had endeavored to improve the systems used to review skill programs, train competent trainers, and ensure adequate data collection. The Monitoring Team's previous reports noted an ongoing weekly peer review process, entitled the Skill Acquisition Review Committee (SARC), used to examine developed SAPs and to provide feedback and refinement. Currently, reports indicated that this	Noncompliance

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		committee continued to meet weekly to review SAPs. Onsite observation by a member of the Monitoring Team confirmed that this committee actively critiqued SAPs, including use of the SARC quality rubric designed to facilitate their critical review. At the Monitoring Team's last visit, it was recommended that the Facility consider revision of this rubric, including targeting the inclusion of behavioral objectives and operational definitions (using only objective and measureable responses), of the specific teaching method (i.e., the type of chaining), of mastery criteria for the identified step, and improved oversight to ensure that task analysis includes only discrete, individual responses (and not staff behavior), and to ensure adequate opportunities for learning. Currently, provided documentation and verbal report indicated that the rubric was revised (in June 2013) consistent with these recommendations. Given the findings of the sampled SAPs (as reported with regard to Section S.1), it appeared these changes had initially been implemented across some of the more recently implemented SAPs. Consequently, the Monitoring Team looks forward to examining the impact of this new rubric during the Monitoring Team's next visit. 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. It should be noted that 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 within all 12 (100%) of the sampled SAPs reviewed, 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, Education and Training Assessment, Risk Rating Assessment, etc.), discussion at the ISP, and/or a task analysis (typically citing the task analysis in the current SAP). Of the 12 sampled SAPs reviewed: ▪ Nine (75%) indicated that they were based on needs identified within FSAs. However, these needs were only conspicuously identified, including specific identification within the assessment and within the summary and/or recommendation section within the FSAs, for six (67%) of the individuals identified. More specifically, it was unclear to the Monitoring Team how the needs targeted by the SAPs for three of the individuals sampled (i.e., Individual #198, Individual #368, and Individual #137) were related to information within current FSAs. ▪ Ten (83%) indicated that they were based on preferences identified within the PSI. In all cases, it appeared that one or more of the preferences identified within the PSI were integrated into the SAP and listed as potential reinforcers. ▪ Eleven (92%) of the SAPs identified "… discussion of training at ISP …" within	

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		the rationale for the sampled plan. As previously noted, the IDT's discussion at the ISP should not replace identification of skill deficits through actual assessments. ▪ Six (50%) of the SAPs identified the task analysis as part of the rationale for the sampled plan. It was unclear to the Monitoring Team how the task analysis was used prescriptively to identify the need being targeted. ▪ Lastly, eleven (92%) of the specific SAPs were identified within the current ISP. The exception was the SAP for Individual #198. Overall, the use of the FSA in identifying the rationale for targets of skill acquisition appeared to improve since the Monitoring Team's last visit. In addition, the integration of identified preferences within SAPs was viewed as a recent improvement as well. However, as noted with regard to Section S.2 above, consistent with previous findings, the current review continued to find the recommendations in FSAs quite brief and non-specific. Indeed, although the new format was utilized for those currently sampled, the FSA only appeared adequately completed for seven (58%) individuals. It continued to be unclear to the Monitoring Team why such a comprehensive and resource-dependent assessment would produce such brief and often cryptic summary and recommendations that often did not make conspicuous how identified needs were prioritized. It should be noted that State Office Discipline Coordinators recently developed a new standardized format for all assessments, with a few exceptions. This new format, scheduled to rollout in October 2013, included the FSA. A review of the revised FSA, consequently, revealed a more comprehensive and integrated summary format. That is, it appeared that more broad and detailed content was requested, including new information related to an individual's history, current status, and services. This format also appeared to facilitate the conspicuous integration of information related to preferences, strengths, and tentative goals (across living, employment, relationships, leisure, and independence areas) from the ISP Preparation Meeting. Prioritization of needs and strengths also appeared to be requested across the familiar FSA skill areas. Overall, the document appeared likely to promote a more comprehensive review and integration of information that might improve the development of more informed recommendations and skill programming. 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, of the 12 individuals sampled, 12 (100%) had at least one SAP targeting completion in a community setting, 11 (92%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings (the exception was Individual #98), and 12 (100%) had at least one SAP targeting completion in the home. Consistent with previous findings, the majority of	

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		SAPs were prescribed for completion in the home settings. However, it appeared that increasing numbers of SAPs had generalization procedures targeting community-based settings. It should be noted that concerns about the adequacy of sampled SAPs were noted above (with regarding to Section S.1 of the Settlement Agreement). However, based on the targeted behavioral objective and the identified setting for training, it appeared that all 12 (100%) of the sampled SAPs provided opportunities for skill acquisition in the most integrated setting. The Facility should be commended for its consistent efforts to improve the skill acquisition development and related staff training, including ongoing revision of documentation, as well as ensuring competency-based testing/monitoring for new and current staff. Indeed, at the time of the Monitoring Team's last visit, the NEO curriculum had been revised and implemented. More recently, evidence provided indicated continued revision of the SAP format (including new generalization and maintenance forms) and training materials (e.g., development of a new PowerPoint presentation for annual refresher training), as well as the recent revision of the rubric used to complete Integrity Checks for SAPs. In addition, the Facility continued to evidence ongoing efforts at ensuring the competency of its Certified Trainers. That is, documentation provided evidenced the training of 35 new trainers, including Residential Coordinators, Home Team Leaders, and other residential staff across all residential programs. Summary documentation (Summary of Integrity Checklists for Skill Acquisition Plans, February – July 2013) indicated that progress had been made in training more staff as Certified Trainers. More specifically, the Facility has been moving to train increasingly more individuals as competent trainers of SAPs, and, based on summary data, it appeared that a total of 48 individuals, including 25 residential staff, have been certified as trainers. Consistent with findings from 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 completed for each program as well as information on the individual, auditor, audit date and integrity (competency) score per month. This database allowed examination of integrity scores across home, unit, and assessor. Provided summary data reviewed at the time of the Monitoring Team's previous report revealed that 86 integrity checks were completed across residential programs between September 2012 and January 2013 and resulted in an overall competency score of 86%. At that time, it was reported that the "Integrity Check for Skill Acquisition Plan" was revised to include more items, specifically targeting the prompt sequence, generalization and maintenance, and to include more items scored directly through demonstration (not verbal report). Currently, provided summary information reaffirmed the expectation that Active Treatment Supervisors and Program Coordinators conducted weekly integrity checks. Indeed, the Facility indicated that a	

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		total of 104 integrity checks should be completed each month, with 52 (50%) of these completed in the presence of a pair of assessors (e.g., both the Active Treatment Supervisor and Program Coordinator). Currently, summary data provided revealed that 368 integrity checks were completed across residential programs between February and July 2013, and resulted in an overall competency score of 87%. More detailed competency scores provided across months indicated a slight decrease in scores following the revision of the integrity checklist in June 2013. Compared to previously reported data, the current findings reflected an improvement in the number of checks completed as well as in the estimated level of integrity. However, the Facility acknowledged difficulty in completing the expected number of integrity checks per month due to the prolonged unavailability of several key staff members who were central to this process. Provided summary data suggested that, during this time period, a total of 368 (59%) out of an expected 624 checks (i.e., based on 104 per month across six months) were completed. It should be noted that this finding might underestimate the percentage of checks completed, because the required number might have decreased following the recent closing of a residence. However, the Facility did not specifically provide this information. Overall, it appeared that the Facility had been monitoring the completion of integrity checks to ensure adequate implementation of SAPs since the Monitoring Team's last visit. In addition, the database appeared to be utilized to monitor competency across programs as well as across items on the rubric over time. A primary concern noted in the past has been the degree to which independent observers agree when scoring items during SAP integrity checks. That is, in the Monitoring Team's previous reports, the Team had questioned the competency of raters when completing these checks, as well as, at times, their independence in scoring the checklists. In response, it appeared the Facility had begun to examine the inter-observer agreement between raters during integrity checks. More specifically, current summary documentation indicated that a random sample of integrity checks was selected for review each month (between February and July 2013) and IOA estimates were identified. Data indicated that during this time period, average monthly IOA estimates ranged from 90% to 99%. In addition, descriptions based on these monthly reviews revealed the Facility's attempt to identify weak areas with regard to implementing and scoring these checks. Overall, the Facility should be commended for examining agreement between raters (which was previously recommended) and working to ensure that all raters are scoring these checks consistently. However, it was still unclear to the Monitoring Team how many integrity checks were included in each monthly sample. In addition, reports continued to suggest that, although half of the integrity checks were completed in pairs, data from these checks were not available in the database to assess reliability over time. It would appear that, once in place, this additional data would be helpful to the Facility in	

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		ensuring the competency of the raters. As described above, concerns have been noted regarding the adequacy of integrity checks during observations completed by a member of the Monitoring Team in the past. Current observations continued to reflect the need for ongoing support and training for active treatment staff members who conduct these sessions. More specifically, staff continued to appear confused regarding some elements within the SAPs (e.g., discriminative stimuli, error correction, forward chaining) as well as how to accurately score staff responses. Most importantly, direct support professionals who volunteered to be observed appeared to have difficulty answering simple questions about the SAPs even with the plan at hand. Indeed, the lack of fluency in implementing SAPs prescribed to occur daily was somewhat surprising. Lastly, raters should consider asking staff to answer questions without reading the answers off of the actual SAP. Items that are simply read by staff do not necessarily reflect their ability to understand the program, their ability to implement the SAP, and might inflate integrity scores. As noted currently as well as in previous reports, the Monitoring Team recognizes that completing integrity checks with a high degree of fidelity and reliability is challenging. The Facility is commended for continuing to conduct these checks, especially given the expectation that 50% will be completed with pairs of raters (i.e., providing the opportunity for IOA), and for continuing ongoing training to ensure these are completed accurately. During the Monitoring Team's previous reviews, it was noted that the Facility had a system in place to ensure adequate data collection with regard to SAPs. Active treatment staff implemented this system that involved weekly checks examining the quality of SAP data collection for each individual across all residences. Data presented within the Monitoring Team's previous report appeared to indicate that the system was effective in promoting high completion rates. Although verbal reports from the Director of Day Programs indicated that this system was still in place, current data was not provided for the Monitoring Team to review. This system appeared necessary and effective and the Facility is encouraged to continue using it to ensure the adequate collection of data. Brief onsite reviews during the Monitoring Team's current visit evidenced mixed findings with regard to the completion of data collection. That is, when data was collected, it appeared to be completed fairly regularly and seemingly as prescribed. Random record reviews examining the collection of data on target behavior(s) indicated that 86%, 100%, 100%, 0%, 100%, and 86% appeared collected as prescribed for Individual #218, Individual #297, Individual #147, Individual #38, Individual #58, and Individual #325, respectively. It should be noted that a behavior data sheet was not located in the record for Individual #177, and the PBSP found in the records of Individual #218 and Individual #325 was expired. Similar brief reviews of skill acquisition plan data indicated that 100%, 100%, 0%, and 100% of the data appeared collected as prescribed for Individual	

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		#218, Individual #297, Individual #58, and Individual #325, respectively. In most cases, it appeared that increased vigilance of data collection by behavioral services and active treatment staff has improved the completion of behavioral and skill acquisition data. In an effort to examine the nature of data collection with regard to skill acquisition programming, raw data sheets corresponding to one SAP from each individual sampled (as identified above with regard to Section S.1) were reviewed. Review of this documentation, including actual data sheets from August and September 2013, indicated: ▪ For individuals with SAPs implemented in August (N=11), adequately completed data sheets for August were provided for six (55%) individuals. Exceptions included those with missing data (i.e., Individual #118 and Individual #98) or seemingly inaccurate data (i.e., Individual #318, Individual #137, and Individual #368); ▪ For individuals with SAPs implemented in September (N=12), adequately completed data sheets for September were provided for seven (58%) individuals. Exceptions included those with missing data (i.e., Individual #98) or seemingly inaccurate data (i.e., Individual #40, Individual #137, Individual #138, and Individual #368). As noted above, review of completed or "raw" data sheets revealed concerns about the completion and adequacy of the data for a substantial number of those sampled. Overall, the current review revealed that, for some individuals, total scores recorded on data sheets did not accurately reflect success as defined within prescribed data collection methodology. For example, scores on the August data sheet for Individual #318 indicated that verbal prompts were required on three out of the four trials. However, instead of scoring the month as 1/4 (25%), as prescribed, the data sheet was scored as 4/4 (100%). A similar situation was noted for the September data sheet for Individual #138. In addition, staff indicated that somewhat more intensive prompts were required in teaching trials where these would be inappropriate. For example, the SAP for Individual #137 targeted eye gazing, and staff recorded the use of model and gestural prompts. Similarly, the SAP for Individual #368 targeted verbal behavior, and staff recorded the use of full physical prompting. Overall, based on the review of the sampled raw data sheets, significant concerns remained with regard to the adequacy of data collection and ongoing monitoring of skill acquisition programming. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility ensure that raw SAP data is collected accurately and completely. The Monitoring Team's previous documentation reviews consistently found the ISP Monthly Reviews inadequate. In an effort to examine the nature of data monitoring with regard to skill acquisition programming, Monthly Reviews for each individual sampled (as identified above with regard to Section S.1) were examined. Review of this	

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		documentation, including the Monthly Reviews from July and August 2013 for the 12 individual sampled, indicated: ▪ Monthly notes from July and August 2013 were available for 11 (92%) of the individuals sampled. The exception was the Monthly Review for Individual #98 that was not provided as requested; ▪ Of the 11 individuals, behavioral objectives as described in Monthly Reviews matched descriptions found in the SAP for 10 (91%) individuals. The exception was Individual #198; ▪ Of the 11 individuals, performance appeared to be adequately described within the text of the review for 10 (91%) individuals. The exception was Individual #198; ▪ Of the 11 individuals, performance appeared to be adequately graphed for 11 (100%) individuals; ▪ Of the 11 with graphic displays, nine (82%) appeared to have the appropriate data displayed. That is, extra data points appeared to be inaccurately displayed in two of those sampled (i.e., Individual #137 and Individual #371); ▪ Of the 10 individuals who attend class and/or work, it appeared that attendance data was provided for nine (90%) individuals; and ▪ Of the 11 individuals, monthly reviews appeared to be completed in a timely manner (within 30 days of the targeted month) for seven (64%) individuals. The exceptions were Individual #137, Individual #19, Individual #93 (not dated), and Individual #371. Overall, the Monitoring Team found the monthly reviews to be greatly improved. That is, they appeared much more comprehensive than those reviewed in the past and all of those sampled included graphic displays of performance that appeared easily interpreted. However, the Facility should consider the appropriateness of multiple X-axes and corresponding multiple data paths (e.g., Step 1, Step 2, etc.). Displaying data this way appeared inappropriate to the Monitoring Team as the steps in a task analysis represent discrete responses that will ultimately be performed as one unified response. Graphing this data as it was currently designed appeared counterintuitive. 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 might not adequately reflect true performance and might lead to misinterpretation. Given the concerns noted above, the Facility remained in noncompliance with this provision of the Settlement Agreement.	

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	(b) Include to the degree practicable training opportunities in community settings.	Continued efforts were noted in ensuring that all individuals had SAPs designed for implementation in the community. However, systems to support their implementation in community remained of concern. As previously reported, the Facility set an expectation that each individual would access the community at least once a month and that these opportunities for community integration be designed based on individual preference and/or training objectives. In an effort to examine the nature of training opportunities in the community for individuals, the Monitoring Team examined a sample of SAPs to determine progress with regard to the provision of formal community-based opportunities. Currently, as described previously with regard to Section S.1, the SAPs of a sample of 12 individuals with ISP meetings held since the Monitoring Team's last visit 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, of the 12 individuals sampled, 12 (100%) had at least one SAP targeting completion in a community setting, 11 (92%) had at least one SAP targeting completion in a vocational/work or classroom/day program settings (the exception was Individual #98), and 12 (100%) had at least one SAP targeting completion in the home. This finding was consistent with those reported in the Monitoring Team's previous report and continue to reflect that the Facility's efforts at ensuring that individuals had opportunities to work on the acquisition of skills in community settings, vocational/work or classroom/day program 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 due to restricted access to community outings. More specifically, as noted in the current Section S Self-Assessment (dated 9/13/13), a review of all the individuals the Facility served indicated that 227 (93%) had SAPs designed to be implemented in the community. The Facility further reported that, of these individuals, 103 (45%) evidenced data that reflected adequate completion of the SAP in the community. In addition, concerns with regard to the quality of these SAPs, as discussed in further detail with regard to Section S.1 limited the potential of these experiences as actual learning opportunities. Based on verbal report from the Director of Day Programs, the Facility planned to develop a system to monitor the implementation and effectiveness of skill training in the community. Information provided within the Section S Presentation Book indicated that this system had not been fully developed yet. As previously reported, the Facility set an expectation that each individual would access	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
		the community at least once a month. As reported in the Monitoring Team's last report, community trips remained relatively frequent for individuals within the Atlantic residential programs. However, similar opportunities for community integration were not evident for individuals within the Pacific and Coral Sea residential programs. At that time, reasons for diminished community integration opportunities included the fact that both homes were on isolation in January 2013. In an effort to examine the nature of ongoing community integration, the Monitoring Team reviewed provided community integration summary data from February through July 2013 (TX-CC-1309-VIII.26). Currently, provided data as displayed by Unit indicated the following: ▪ The total community trips for the Atlantic Unit averaged 374 per month, and ranged from 306 to 432 trips; ▪ The total community trips for the Coral Sea Unit averaged 33 per month, and ranged from 20 to 52 trips; ▪ The total community trips for the Pacific Unit averaged 44 per month, and ranged from 18 to 67 trips; Currently, provided summary data as displayed across residential programs within specific units indicated the following: ▪ The total community trips for Ribbonfish 1 averaged 23 per month, and ranged from 14 to 35 trips; ▪ The total community trips for Ribbonfish 2 averaged 22 per month, and ranged from 13 to 33 trips; ▪ The total community trips for Ribbonfish 3 averaged 13 per month, and ranged from five to 20 trips; ▪ The total community trips for Ribbonfish 4 averaged 11 per month, and ranged from six to 14 trips; ▪ The total community trips for Sand Dollar averaged 19 per month, and ranged from seven to 29 trips; ▪ The total community trips for Sea Horse averaged 19 per month, and ranged from two to 33 trips; ▪ The total community trips for Kingfish 1 averaged 56 per month, and ranged from 36 to 64 trips; ▪ The total community trips for Kingfish 2 averaged 119 per month, and ranged from 92 to 147 trips; ▪ The total community trips for Kingfish 3 averaged 90 per month, and ranged from 44 to 113 trips; ▪ The total community trips for Kingfish 4 averaged 111 per month, and ranged from 74 to 148 trips; and ▪ The total community trips for Dolphin averaged 180 per month, and ranged from 164 to 198 trips.	

#	Summary of Provision	Assessment of Status	Compliance
		Overall, it appeared that frequent opportunities for community trips were available at residential programs in the Atlantic Unit. Indeed, as a unit, Atlantic offered the most opportunities for community inclusion. However, although opportunities appeared more frequent, these opportunities appeared to reflect a decreasing trend since June 2013. Compared to residences within the Atlantic Unit, less frequent opportunities for community inclusion were found for individuals living in residences within the Pacific and Coral Sea Units. This finding was consistent with results from the Monitoring Team's previous reviews. Nonetheless, provided data indicated that opportunities for community integration appeared to be increasing slightly over time within the Pacific Unit, despite considerable variability in reported outings for residents of Ribbonfish 1 and Ribbonfish 2. Lastly, opportunities for community integration had decreased sharply for residences within Coral Sea over this time period. Documentation provided to the Monitoring Team appeared to offer several reasons for the declining opportunities for community integration, including lack of critical staff (including community integration specialists and van drivers), difficulties requesting funds for outings, and challenges related to the recent changes in Unit Directors. Issues related to the lack of appropriate transportation had been overcome as several new para-transit buses had been obtained in the last 12 months, including an additional van that was just recently purchased. Overall, the Monitoring Team was encouraged by the increasing trend in opportunities for community integration reported for residences in the Pacific Unit. However, serious concerns were noted with regard to the declines noted in opportunities for community integration within the Coral Sea and Atlantic Units. It should be noted that data found within the provided summary documentation (i.e., Community Integration Report, February 2013 – July 2013; TX-CC-1309-VIII.26) appeared inconsistent. More specifically, the Monitoring Team was unclear why the total number of community trips per unit (across months) did not correspond with number of community trips per homes in that unit. For example, for the month of February, it was reported that the Atlantic unit had 357 community trips. However, when community trip data was displayed by home (i.e., including all four Kingfish homes as well as Dolphin), 543 total outings were reported. This Monitoring Team found this inconsistency across all comparisons between units and corresponding residential programs. In addition, community outing data presented within this summary did not match community outing data presented within the Section S Self-Assessment (dated 9/13/13). Despite the potential errors noted here, the Facility should continue monitoring community outings data, perhaps using 12-month periods to better estimate trends over time, and consider examining and reporting percentage of individuals participating in outings per month across each residence as well.	

#	Summary of Provision	Assessment of Status	Compliance
		Due to the continued inadequacy and concerns related to ensuring adequate training opportunities in the community, the Facility remained out of compliance with this provision of the Settlement Agreement. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility improve access for all individuals with regard to skill training opportunities in the community.	

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 2/1/13 and 7/31/13, dated 8/17/13; o List of individuals currently referred for community placement, dated 8/17/13; 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 8/17/13; 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 8/17/13; 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 2/1/13 through 7/31/13; 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 Individuals Participating in Community Tours (Unduplicated), from 7/1/12 through 7/31/13; 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 Documents or materials provided to staff to inform them of community living opportunities; o Flyer for Community Living Options Awareness Expo, on 8/15/13; o Home and Community Services presentation documentation, for training on 9/17/13; o Family Association Meeting agenda, for meeting on 8/24/13; o Statement regarding what the meeting date on the Community Placement Report represents; o Community Living Discharge Plans (CLDPs), including individuals' most recent ISP and

	related assessments for Individual #353, Individual #172, Individual #112, Individual #94, Individual #74, Individual #221, and Individual #355; o List of individuals transferred to other SSLCs, dated 8/17/13; o List of alleged offenders, dated 8/17/13; o Summary of the obstacles identified for individuals' movement to the most integrated setting, dated 8/23/13; 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 #97, Individual #353, Individual #13, Individual #46, Individual #61, Individual #269, Individual #183, Individual #9, Individual #290, and Individual #367; o List of Post Placement Monitoring, dated 7/26/13; o Newest Post-Move Monitoring template, dated September 2013; o Post-Move Monitoring Helpful Hints, dated October 2013; o DADS Draft Most Integrated Setting Practices policy, undated; o Post-Move Monitoring Checklist for Individual #112; o Pre-Move and Post-Move Monitoring documentation for the following: Individual #221, Individual #74, Individual #26, Individual #47, Individual #208, Individual #355, Individual #62, Individual #71, Individual #341, and Individual #353; o Last 10 monitoring tools completed by: a) Admissions Placement Coordinator; and b) Quality Assurance Department staff, various dates; o Draft Potentially Disrupted Community Transitions Process, dated 8/29/13; o Meetings between QA Department/Placements Department, undated; o Based on monitoring data and/or key indicators related to the provision of supports in the most integrated setting, reports showing analysis of such data, as well as descriptions of actions taken or corrective action plans developed; o For Individual #27, team meeting documentation in relation to his return to the Facility from a community placement;

	○ Discharge summary and related assessments for: Individual #109; ○ State Office review of the CLDPs for: Individual #74, and Individual #355; ○ List tracking individuals transitioned past 180 days; ○ Admissions Placement Department Due Dates for Community Referral; ○ Admissions Placement Department 45-Day Discharge Summaries Pending for CLDP; ○ CCSSLC Self-Assessment for Section T, updated 9/13/13; ○ Action Plan for Section T; ○ CCSSLC Provision Action Information for Section T; and ○ Presentation Book for Section T. ▪ **Interviews with**: ○ Esmerelda Vogt, Admissions Director; ○ Sandra Vera, Post-Move Monitor (PMM); ○ Laura Maldonado, Placement Coordinator; ○ Elena Martinez, Program Compliance Monitor; ○ Monica McDermott, Transition Specialist; and ○ Rachel Martinez, QDDP Coordinator. ▪ **Observations of**: ○ ISP meetings for Individual #70, and Individual #333; and ○ Post-Move Monitoring visit for Individual #112.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T, dated 9/19/13. 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 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: ○ 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. ○ 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. 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. 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, 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%, the validity of the findings 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. 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 had begun to identify some "key indicators," but more work was needed to both identify key indicators of quality (e.g., "# of persons moved with assessments updated within 45 days prior to the move," was an important indicator, but did not address the quality of those assessments), and to define them as measurable goals. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically: o Self-assessment activities did not consistently measure the quality as well as presence of

	items. For example, 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. o 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 how many ISPs included discussions of living options, and if living option discussions occurred outside the ISP. Neither of these captured the specific requirements from the State Office related to assessment. o 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 relates to the development of CLDPs; 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.d, which relates to the 45-day assessments for CLDPs (according to the narrative, but not the compliance column); 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.h, T.2.a, and T.2.b. ▪ The Facility data identified areas in need of 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. The Facility sometimes connected the findings to portions of the Facility's Action Plans or corrective action plans it had developed to make improvements. However, many of the summaries showed a lack of understanding of what the Settlement Agreement required. Just as a couple of examples, for Section T.1.c.1, which relates to specifying actions in the CLDPs for the SSLC and coordination with providers, the Facility's data indicated 100% compliance. However, the Self-Rating indicated the Facility was not in compliance with this provision. The Facility concluded: "This provision is not in compliance as CLDPs need to document intervening months of the community referral." It was not clear what this meant, but it showed a lack of understanding of why the Facility was out of compliance with this provision. For Section T.1.e, the Facility appeared to believe that the only issue with pre- and post-move supports was their measurability.
	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 or justify the obstacles to referral. In addition, although teams were developing action plans to address obstacles to referral, they were not individualized. In reviewing CLDPs, at least two individuals were returning to CCSSLC to participate in the work/vocational program, and providers were working to identify vocational supports for them in the community (i.e., Individual #94 and Individual #112). 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, supports, 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 provision of pre- and post-move supports, and substantiate the findings (e.g., interviews, document reviews and observations). The QA Nurse had been identified as a resource for the Post-Move Monitor for individuals moving to the community with more extensive medical and physical and nutritional support needs. This was a positive development in bringing more clinical expertise to the post-move monitoring process. In addition, progress had been made in involving IDTs in the Facility's efforts to take reasonable 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 criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take	As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United 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	Noncompliance

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	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.	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. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this 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 eight 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 delays. This was an ongoing problem. Based on information the Facility provided, between 2/1/12 and 9/30/13, 10 individuals had transitioned more then 180 days past their referral date. For the eight individuals currently on the referral list that were past 180 days, their referral dates ranged from August 2011 through March 2013. As is discussed in further detail with regard to Section T.1.g, the Facility had begun to collect data on obstacles to individuals' transition to community settings. This data was not complete, but it showed that for six individuals obstacles included the need for behavioral supports, and for three individuals, the need for specialized medical supports was the obstacle. As the Monitoring Team has stated in the past, it is of utmost importance that individuals transitioning to the community have the protections, supports, and services they need to lead safe, meaningful, and productive lives. Teams are encouraged to continue to thoughtfully assess the options available to individuals, and assist individuals and their guardians to make informed decisions about the community providers they select. However, these were areas in which more systemic attention is needed from DADS State Office. In reviewing CLDPs and ISPs of those individuals that were referred, none of them or their guardians had opposed transition to the community. 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 full implementation within two	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 that the State Office was going to issue an updated policy related to Most Integrated	Noncompliance

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	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:	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, it was only shortly after the onsite review that DADS issued a revised policy. The Monitoring Team will review and comment on the policy in the next report. 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 at the time of the onsite review, 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 current 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 10 ISPs, teams generally had identified some obstacles. Of the 10 ISPs reviewed, eight should have had obstacles defined. The remaining two individuals had been referred for transition to the community (i.e., Individual #353 and Individual #61). Of the eight remaining plans, two (25%) included an adequate list of obstacles (i.e., Individual #13, and Individual #46, which identified LAR Choice and provided some specifics about the LAR's concerns). 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 or the full set of the concerns were not identified on the list in the ISP (e.g., for Individual #97, the team identified the guardian's choice as an obstacle, 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. Many potential concerns that guardians or individuals might have were not available options on the list in the ISP; and ▪ Some were not adequately justified:	

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		o For a number of individuals, the obstacle identified was Individual Choice – Lack of understanding of community options. However, based on other information in the ISPs, teams indicated that these individuals could not make informed decisions. For none of these individuals had teams identified viable mechanisms for learning more about their understanding of community options or their specific preferences, and for many individuals, this would be difficult to do. Therefore, absent guardians, it appeared that the teams would need to make decisions related to community transition for them (e.g., for Individual #269, the obstacle the team identified included "Individual choice - lack of understanding of community living options," but in the rights section of the ISP, the team indicated that: "Due to her profound intellectual developmental disability, [Individual #269] is unable to give informed consent in the areas of medical, programmatic... Her IDT along with input from her family make these decisions for her." Similarly, the obstacle listed for Individual #290, Individual #367, Individual #183, and Individual #9 were Individual Choice - Lack of understanding of community living options.). o For some individuals, either "Medical Issues" or "Behavioral Health/Psychiatric Issues" were listed as obstacles, but the teams did not identify the specific supports that they believed were not available in the community to meet individuals' needs (e.g., Individual #183 for "Medical Issues," or Individual #97 for "Behavioral Health/Psychiatric Issues). Moreover, action plans to overcome the obstacles identified generally were not adequate. Of the eight ISPs, eight (100%) included an action plan to overcome obstacles identified. Of these eight, none (0%) were adequate. Although the plans could generally be measured (except for Individual #9), they were not individualized. Most of the plans included the generic actions steps of going on group home tours and attending provider fairs. The plans had not been individualized to reflect tours to homes or day/vocational programs that could specifically meet the individuals' needs, mechanisms for evaluating individuals' reactions to the tours, visits to friends who lived in community settings, development of tools to assist individuals or their guardians to ask specific questions about providers' service array, or targeted education about the types of supports available in the community that would specifically meet individuals' needs. Few action steps had been designed to address guardians' specific concerns about transition to the community. 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	

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		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. As noted in the Monitoring Team's last report, the Facility had begun to collect information on the obstacles to individuals' transition to the community. At the time of the most recent review, the Facility submitted data on 21 individuals listing 29 obstacles to movement to the most integrated setting appropriate. The following represents the obstacles identified, and the number of individuals for whom the obstacle was an issue: ▪ Behavioral Supports – six; ▪ Employment/Supported Employment – none; ▪ Environmental Modifications – one; ▪ Individual/LAR Indecision regarding Provider Selection – 14 ▪ Limited Residential Opportunities in Preferred Area – five; ▪ Medical/ Supplemental Security Income – none; ▪ Services/Supports for Forensic Needs – none; ▪ Specialized Education Supports – none; ▪ Specialized Medical Supports – three; ▪ Specialized Mental Health Supports – none; ▪ Specialized Therapy Supports – none; and ▪ Transportation Modification – none. This was a positive step forward. However, concerns about the accuracy of the data existed. For example, as noted in the Monitoring Team's last report, 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. However, on the list of obstacles to transition, no obstacles were listed for "Employment/Supported Employment." Since the last review, no progress was seen in identifying or addressing obstacles to referral. CCSSLC was identifying obstacles to community transition, but problems still existed with the accuracy of this data. 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	As described in previous reports, CCSSLC had engaged in a number of activities to provide education about community placement opportunities to individuals and their	Noncompliance

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	education about available community placements to individuals and their families or guardians to enable them to make informed choices.	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: ▪ **Provider fairs**: Since the last review, a provider fair was held on 6/11/13. As noted in the Monitoring Team's previous report, based on data provided, participants at the previous fair included 65 individuals, four family members (i.e., all family members for one individual), 75 staff, and seven HCS providers. For the fair in June 2013, 142 individuals, no families, 136 staff, and 15 providers attended. These numbers showed good increases in individual, staff, and provider attendance. Based on discussions with Admissions Placement Department staff, these increases were attributed to the most recent fair being held on a Tuesday as opposed to the Saturday fair in 2012. As a result, more staff and individuals were on campus. In addition, staff sent "save-the-date" notifications to providers sooner, earlier notices of the upcoming fair were provided to teams, and more reminders were sent within the Facility. Based on interview, a number of individuals that had transitioned recently to the community came with the provider representatives, and were available to share their stories. This was a good addition to the provider fair. Based on the information provided, it did not appear that formal analysis had occurred of the data, or outcome measures had been established and implemented 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. This was part of the Facility's action plan for Section T, but was listed as "In process." ▪ **Education about community options:** Individuals and their guardians also were provided information through the following: o On 8/15/13, the 3rd Annual Community Living Options Awareness Expo 2013 was held on the CCSSLC campus. One of the Local Authority CLOIP departments sponsored the event. Vendors included various groups from the community, including advocacy groups, public resources (e.g., police, fire, transportation), and employment services. 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	

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		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. This was part of the Facility's action plan for Section T, but was listed as "In process." o As indicated in the Monitoring Team's last report, 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 had developed a similar Resource Directory, so 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). For this most recent review, the Facility provided data showing an unduplicated count of individuals that had participated in the tours. From 7/1/12 through 7/31/13, 71 individuals participated, or approximately 29 percent of the individuals residing at the Facility. Based on the data provided, the majority of these individuals had attended one tour during the course of a little over a year. 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. Although reportedly, a process was in place to document individuals' responses. ▪ **A plan for staff to learn more about community options**: In the Monitoring Team's last report, it was noted that the Facility's action plans included part of a plan to train staff. Specifically, the plan addressed QIDPs, Psychologists, nursing staff, Habilitation Therapists, and vocational services staff. The Monitoring Team noted that those not specifically included in the plan included: management staff, other clinical staff, and direct support professionals (except at New Employee Orientation). Since then, the Facility had added the following to its action plan: "Others as requested (management staff, other clinical staff, and direct support professionals)." It was unclear why these staff would only be trained "as requested." In addition, the Facility still did not present a formalized training plan (i.e., a plan that described who would be trained, how often, using what curriculum, etc.).	

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		Through sign-in sheets and logs, it appeared staff participation in various training opportunities was being tracked, such as for New Employee Orientation, training in March 2013 on the community transition process, and the Home and Community Services presentation on 9/17/13. However, it was not clear if data regarding staff training were being aggregated and analyzed. ▪ **Individuals and families have opportunities to learn about success stories:** The Facility had not yet addressed the following areas adequately: o As noted above, the Provider Fair had included the participation of some individuals that had transitioned to the community. This was a good way to share success stories. The Facility should expand its efforts to 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, or small group settings); o The Facility should provide opportunities for individuals to visit friends who live in community. Although the Facility indicated that individuals and guardians were able to interact with individuals who had moved during pre-selection visits and community exposure tours, more could be done to provide opportunities for more individualized visits; 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, on 8/24/13, a member of the Admissions Placement Department had presented at the Family Association meeting. Only one family member attended. In addition, a Transition Specialist had continued to present at the Self-Advocacy meetings, as invited. It did not appear that the Facility was currently engaging in educational during house meetings. ▪ **Regular SSLC meeting with the Local Authority:** Meetings with staff from the Local Authorities were occurring. Relevant topics were discussed, including coordination between the Facility and Local Authorities, as well as CLOIP tours, and the provider fair. An issue had been identified with local providers accepting tours. The Facility staff were working with the Local Authorities, and had discussed the issue with State Office staff. ▪ **Individualized Plans:** The most challenging area with regard to education of	

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		individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing 10 recently completed ISPs, two individuals had been referred to the community. For the remaining eight, eight (100%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following concerns were noted: o None (0%) of the plans were individualized to address the individual and/or the LAR's particular needs or concerns. 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 (except for one action step in the plan for Individual #13 related to the LAR's concern about whether a return to CCSSLC was possible should the transition not work out), 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 generally could be measured in terms of whether or not the limited activities described occurred. However, none 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. 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 based on the sample of individuals reviewed, individuals had plans 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	

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		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.	As noted in the last report, in assessments prepared for annual ISP meetings, assessors' recommendations regarding transition to the community generally were included. Some assessments still did not include such recommendations, particularly psychiatry and the FSA. 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 transition 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 the review of the sample of 10 ISPs listed in the documents reviewed section: ▪ 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 ISP meeting, the team needed to make a recommendation to the individual/guardian. Based on the review of records: o Of the 10 ISPs reviewed, for five (50%) (i.e., Individual #269, Individual #353, Individual #97, Individual #183, and Individual #61), all of the assessments included the applicable statement/recommendation. For the remaining individuals, the assessments that did not include recommendations included: the Functional Skills Assessment, psychiatry, education and training, and nursing. Of note, at times the statements that were included either did not follow the State Office format. Of concern, some of the psychiatric assessments in particular showed a lack of understanding of individuals' right to live in the most integrated setting. For example, for Individual #13, the following statement was included: "I may add that he is a high-functioning individual capable of moving out into a group home, which would be convenient for him to go an visit his parents, unless he becomes a nuisance for the family members, in which case he should be here or in San Antonio State School, which is closer to his parents' home." o Of the 10 ISPs reviewed, two of the individuals had been referred for transition to the community (i.e., Individual #353, who previously had been referred and the team continued the referral, and Individual #61).	Noncompliance

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		For the remaining eight individuals, seven individuals' ISPs (88%) included a recommendation from the professionals on the team to the individual and LAR. The one that did not was Individual #367. For only three of these individuals (43%) was adequate justification provided (i.e., Individual #97 and Individual #13, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #269 for whom the team recommended transition). The following provide examples of inadequate justification for teams' conclusions: ▪ For Individual #9, the ISP listed only some of the assessment recommendations, but all of those listed indicated that Individual #9 could be supported in a less restrictive setting. The professional members of the team recommended that he not be referred, but no justification was provided for team members changing their initial recommendations. The explanation provided largely revolved around the team not knowing what the individual's preferences were. He did not have a guardian. Although the team indicated his family wanted him to remain at CCSSLC and to be "a voice" in his life, another section of the ISP indicated that he "does not have involved interactions with his family. It has been sometime [sic] since he has seen his family." The team indicated he refused to get in a van to leave CCSSLC. However, it was unclear if it was the van itself or riding in it that he did not like, or if this was an indication that he wanted to remain at CCSSLC. ▪ For Individual #183, according to the ISP narrative, all assessments submitted included a statement indicating he could be supported in a less restrictive setting. However, without justification, the professional members of the team recommended that he not be referred for transition. The professional members of the team indicated Individual #183 could not communicate verbally, so his preferences were not known, and they could not get in touch with the family to discuss options. He did not have a guardian. ▪ The narrative of the ISP indicated that all of the assessments included statements that Individual #46 could be supported in a less restrictive setting. However, without justification, the professional members of the team indicated that they did not recommend transition to the community. The ISP narrative indicated that this was based on the family/guardian's preference. This recommendation should have been made	

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		independent of the individual and guardian, and then the overall decision should have incorporated the wishes of the guardian. ▪ For Individual #290, the ISP summarized the statements made in the assessments, and indicated that all but two discipline members believed he could be supported in a less restrictive setting. The two that did not were psychiatry and audiology. This was not consistent with the Monitoring Team's review of the actual assessments, because these assessments either did not include a statement (psychiatry) or indicated he could be supported in a less restrictive setting (audiology). Although no discussion to remedy these different opinions or provide justification was documented in the ISP, the discipline members concluded that Individual #290 would not benefit from transition to the community. o In ten of the ten (100%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included. However, of these, five (50%) included appropriate justification (i.e., Individual #353 and Individual #61 who were appropriately referred; Individual #97 and Individual #13, whose teams recommended transition, but the guardians chose not to pursue transition; and Individual #46, whose guardian made the final decision not to make a referral). Examples of concerns included: ▪ For Individual #269, the professional members of the team recommended that she be referred for transition, because her "needs can be met in a less restrictive setting." However, the overall conclusion was that she not be referred. The only obstacle identified was individual choice due to lack of understanding of community living options. In the rights section of the ISP, the team indicated that: "Due to her profound intellectual developmental disability, [Individual #269] is unable to give informed consent in the areas of medical, programmatic... Her IDT along with input from her family make these decisions for her." It was unclear how the team expected this would change, or how Individual #269 would overcome her lack of understanding of community living options. Given that the discipline team members agreed she could be supported in a less restrictive environment, she should have been referred. ▪ The ISPs for Individual #290, Individual #183, Individual #367, and Individual #9 did not include adequate justification for the	

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		teams' decisions. During the onsite review, the Monitor observed Individual #333's and Individual #70's ISP meetings. Similar to what was found in the review of ISP documents, most discipline representatives indicated that these individuals could be successfully supported in community settings. For Individual #333, nursing and medical assessments indicated his medical needs could not be met in the community, and the medical assessment for Individual #70 indicated the same. For Individual #70, the Local Authority pointed out that the challenge would be finding a provider that could support his physical needs. Although the teams discussed some of the supports the individuals would need, neither team identified specifically what supports they believed could not be provided in the community. In addition, the team for Individual #333 identified the only obstacle as Individual Choice – lack of understanding of community options. If medical issues were obstacles, then this should have been indicated, and a plan developed to overcome the obstacle. Neither team provided adequate justification for their recommendation, and neither adequately reconciled the discrepancies in the individual discipline members' recommendations. The Facility remained out of compliance with this provision. Although progress had been maintained 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 generally 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 Monitoring Team's 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. Community Living Discharge Plans were reviewed for six of the eight individuals who had transitioned from the Facility to the community since the Monitoring Team's last review, representing 75% of this group of individuals. These included the CLDPs for Individual #355, Individual #221, Individual #74, Individual #94, Individual #353, and Individual #112. With regard to the timeliness of the Community Living Discharge Plans, none of the plans themselves included documentation to show that they were developed sufficiently prior to the individual's transition. Based on the dates included in the plans, they all appeared to have been developed only a few weeks prior to the individuals' transitions. However,	Noncompliance

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		based on other documentation provided, it appeared that teams were, at a minimum, having pre-CLDP meetings a few weeks prior to the individuals' transition meetings, and teams also were meeting shortly after the referrals were initially made. Given the change to the CLDP format, it will be important for teams to clearly document their efforts with regard to transition planning between these meetings. These efforts could be documented in ISPAs or other documentation. 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 six 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, some of them did not define which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and none of them identified what level of mastery of the information was required (e.g., demonstration of competence). As just a few examples, for Individual #74 and Individual #355, it was unclear how their teams determined that it was appropriate for only the community provider's management staff to be trained. No supports were included to ensure direct support professionals, and others involved with their care would be trained. For Individual #221, no training was identified for key components of his supports, such as his PNMP and dining plan. ▪ 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. ▪ None of the plans included 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. ▪ 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	Noncompliance

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		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. ▪ 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 six of the plans reviewed (100%). The Facility was found to be in substantial compliance with this provision. However, a concern was noted in some of the more recent plans that the Facility should address to maintain substantial compliance next time. For some supports in some plans, instead of providing a due date or frequency, in the column labeled "Comments/Due Date," the Facility listed the post-move monitoring dates. Although for the plans reviewed, timeframes were either listed in the support itself, or these were ongoing supports, the "due date" column should be used to clearly define the date or frequency of the supports provided, and not be used to define when required monitoring will occur. This could cause confusion on the part of community providers in terms of their responsibilities.	Substantial Compliance

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	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Based on review of six CLDPs, three of six (50%) included documentation that the plans had been reviewed with the individual and/or the LAR. The plans that did not include such evidence and for which no explanation was provided included those for Individual #355, Individual #221, and Individual #74. The Facility had been in substantial compliance with this provision during the previous review, but lost the substantial compliance rating. This was due to a decrease in the Facility's performance.	Noncompliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	As the Monitoring Team has noted in previous reports, issues existed with regard to both the availability of assessments, as well as their quality. Consistently, the Monitoring Team found that the assessments did not provide the IDTs with adequate information with which to develop an appropriate CLDP or to offer community providers 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. A review of the nursing documentation and Nursing Discharge Assessment Summary for eight individuals (i.e., Individual #71, Individual #208, Individual #47, Individual #26, Individual #221, Individual #109, Individual #74, and Individual #355) found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individual. ▪ 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 for the individual was conducted at the time of the discharge from the Facility and documented in the IPNs for none (0%). ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental health issues for the individual in none of the eight (0%) records reviewed. The Facility had developed a tracking system for the timeliness of the 45-day assessments. This was a positive development. However, neither psychiatric nor medical assessments were tracked on this log. These were significant oversights. With regard to tracking the availability, timeliness, and quality of assessments: ▪ For one of the six CLDPs reviewed (17%), all assessments were provided in a timely manner. For the remaining five individuals, one or more assessment was submitted prior to the 45-day time period. In addition, for three individuals, one or more assessment was submitted after the final community living discharge	Noncompliance

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		meeting was held (i.e., Individual #353, Individual #112, and Individual #94). 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. Of additional concern, many assessments were dated the day of the individual's CLDP, making it difficult for the team to review assessments prior to the meeting. ▪ In addition, the quality of these assessments was lacking. None of the six CLDPs reviewed (0%) were based on adequate assessments. In particular: 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	

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		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. In addition to significant quality issues related to the assessments available, there continued to be assessments that were completed before the 45-day timeframe, or were updated after the individual's CLDP meeting was held. 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 and the previous 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 consistently 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 six 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	Noncompliance

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		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 knowledge, the foundation for the CLDP could be built. ▪ Although clinical services (i.e., psychology/behavioral services) were sometimes now referenced in the CLDPs, they still often were missing. Sometimes, the qualifications of staff were identified (e.g., for Individual #94, his CLDP identified the need for a BCBA to review his PBSP). However, this was not consistent across CLDPs. None of the CLDPs specifically identified the need for nursing staffing, and/or the qualifications of such nurses (i.e., RN or LVN). In addition, the roles of nursing staff were not clearly defined (e.g., for Individual #353, who had a number of diagnoses requiring nursing oversight). Similarly, other than one plan that referenced a dietician, none of the plans that should have defined the roles of Habilitation Therapists did. In addition, the intensity of the supports was not identified. Supports defined as "be seen by a BCBA 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 plans/IHCPs were not referenced as required supports in the CLDPs reviewed. Likewise, individuals who were receiving habilitation therapies supports at CCSSLC did not have functionally equivalent supports identified in their CLDPs. For example, Individual #221 had habilitation therapy supports at CCSSLC, but no supports were included in the CLDP to ensure he had functionally equivalent supports when he transitioned to the community. As discussed further below, individuals with nursing supports at CCSSLC had no equivalent support identified in the transition plan. ▪ 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	

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		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. ▪ In removing any support that the individual utilized at the Facility from the array of supports that would be provided in the community, teams should justify 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 Behavioral Health Services, 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. Of significant concern, the team for Individual #94 reduced his level of supervision without adequate justification. In fact, the psychological assessment indicated: "1:1 staff while off the home due to history of inappropriate sexual/social behavior and physical aggression." Without adequate explanation, the team discontinued this support in the transition plan. ▪ Teams generally 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. ▪ 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, none of the CLDPs reviewed identified post-move supports for the full set of plans implemented at the Facility (e.g., nursing care plans, PNMPs, and PBSPs) to be implemented in the community. Just as a few examples, Individual #353 had clear nursing needs, but no mention was made in the pre- or post-move supports of the need for nursing care plans, or even what nursing staffing was necessary. Similarly, Individual #221 had nursing needs as well as the need for implementation of a PNMP and dining plan, but no mention was made in the pre- or post-move supports for these to be implemented. ▪ Many of the individuals reviewed had specific health care indicators that needed 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 (e.g., Individual #353's blood glucose checks). ▪ 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. ▪ Direct support staffing ratios and requirements (i.e., supervision level) generally were not specified, or were stated in general terms (e.g., "24-hour awake staff).	

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		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, communication strategies, etc.). ▪ Generally, day and vocational supports were not well defined. In addition, at least two individuals were returning to CCSSLC for work/vocational programs (i.e., Individual #94 and Individual #112). Although their CLDPs made the community provider responsible for identifying opportunities for them in the community, few, if any, parameters for the types of supports needed were included in the CLDPs (e.g., staffing supports, types of jobs, etc.). ▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) 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. For example, for Individual #355, supports such as: "will participate in community outings," or "medications will be monitored" were not measurable. 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 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 three individuals' pre-move site visit documentation, as provided by the Facility (i.e., Individual #221, Individual #74, and Individual #47). All three (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. Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress had been sustained 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.	

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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 were estimated at 100%, the validity of the finding was questionable, particularly given the differences between the Facility's findings and the Monitoring Team's findings, as well as State Office's feedback on the CLDPs. 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. Areas in which continued efforts needed to be made included: ▪ The accuracy/validity of the monitoring data was highly questionable. As discussed while on site, the Facility's review of CLDPs showed 100% compliance with the identification of pre- and post-move supports. This was not consistent with either the Monitoring Team's findings or reviews State Office had completed. Although State Office was not consistently identifying all of the issues with CLDPs, their comments for Individual #355's CLDP identified numerous relevant concerns, particularly with regard to missing pre- and post-move supports. When asked how such input from external sources was being used, Facility staff were not able to explain the discrepancies between their findings and others' findings or present a plan for how improvements would be made. ▪ 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 10/10/12 and 8/9/13. Based on the data the Facility provided, of these 15 individuals, a total of five individuals experienced potentially negative outcomes, but no critical reviews were submitted. It should be noted that in reviewing post-move monitoring documentation, it appeared that other incidents had occurred that should have been reported with this data (i.e., two other police contacts, one additional change in provider due to being "kicked out" of one day program due to behavioral issues, and one additional ER visit). It was unclear why these discrepancies occurred. It could have been due to the	Noncompliance

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		timing of the document production, but it appeared it might be a problem with accurate reporting. The following described the information provided that was not analyzed in any meaningful way: o One individual had police contact after an unauthorized departure from the group home. She was taken to the psychiatric unit for 72 hours, and then was transferred to a different provider agency at her request. o Another individual was arrested after breaking into a neighbor's home, and then moved to another provider agency's group home. o Another individual had three Emergency Room visits. It was difficult to determine if any of these resulted in hospitalizations. After the third ER visit, he was admitted to a skilled nursing facility due to the need for intravenous antibiotic treatment. Facility staff reported this was a temporary measure, and he had returned to the group home. o Another individual had police contact and was taken to a psychiatric facility, where he remained for four days, and was released with medication changes. o For another individual, the police were called because she was "having a behavioral incident at the day hab and her behavior was not deescalating." When police arrived, she stated she was dizzy, and Emergency Medical Services was called. 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. The Facility presented a document entitled: "Potentially Disrupted Community Transitions Process." It was positive that an expectation had been set for reviews of certain events post-transition. However, the list of events was missing some important ones, such as review of police contact, return to the Facility, serious injuries (regardless of number of ER visits in a three-month period), restraint, and review of changes in placement other than change of providers. In addition, the prompts on the ISPA template likely were not sufficient to ensure a critical review, particularly review of CLDPs. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred. Based on review of a document entitled: "Meetings Between QA Department and Admissions/Placement Department" listed meetings held in May, June, and August 2013. The document listed the topics discussed, including the monitoring tools completed for specific review periods. However,	

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		no analysis of the data was summarized, and despite significant ongoing problems with CLDPs, no data were included to show what the findings of the reviews were and no recommendations were included for improvement. This likely was because the data was invalid, and showed no issues with the CLDPs. Some Corrective Action Plans had been created for Section T, but none related to the need to substantially improve CLDPs. No progress had been made in this area. The Facility should take steps to improve 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; and ensuring the review results are valid. 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	On February 26, 2013, DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. In its last report, the Monitoring Team provided detailed comments on the Obstacles report, which explained both the positive aspects of this report, as well as the reasons for ongoing noncompliance. The annual obstacles report had not yet been updated since the time of the previous monitoring review, and, therefore, no new comments are provided here. As noted in the Monitoring Team's last report, improvements in data collection and analysis, implementation of revised ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	Noncompliance

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	feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	In response to a document request, the Facility submitted a Community Placement Report. For the time period between 2/1/13 and 7/31/13, the report listed: ▪ Current Referrals: Sixteen individuals were included on this list, but four of these individuals had transitioned to the community since the report was issued. ▪ Community Placements: Eight individuals were included on this list. As noted above, four additional people had transitioned in the weeks prior to the review. ▪ Rescinded Referrals: Three individuals were included on this list. The reasons were IDT decision: Behavioral/Psychiatric; LAR Choice; and IDT decision: 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 community. For meetings occurring between 2/1/13 and 7/31/13, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included two individuals. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included three individuals. For one individual, citizenship issues were identified as the reason. For two other individuals, the reason listed was behavior/psychiatric issues. 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 two individuals (i.e., TX-CC-XVI.4). However, this was a list of individuals who preferred community placement, but were not referred due to LAR choice. This was not responsive to the document request. 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 data the Facility had was reliable. However, this list should have included all individuals for whom the team recommended transition, but the reason a referral was not made was LAR choice. For example, in reviewing ISPs, the Monitoring Team identified Individual #97 and Individual #13 for	Substantial Compliance

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		whom the professionals on the team recommended community transition, but the guardian opposed it. A referral was not made based solely on guardian choice. These individuals should have been on the list the Monitoring Team requested.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for 10 individuals (i.e., Individual #221, Individual #74, Individual #26, Individual #47, Individual #208, Individual #355, Individual #62, Individual #71, Individual #341, and Individual #353). This sample represented all (100%) of the individuals for whom the CCSSLC Post-Move Monitor needed to complete reviews since the Monitoring Team's last review. For the 10 individuals, 18 reviews should have been completed during this time period. Of the 18 required visits, all (100%) had been documented as having been completed on time. <u>Visits to All Sites</u> The Facility continued to ensure that visits had been made to both the residential and day sites of the individuals, and that this was documented in the reports. The Facility had used a variety of forms to document its post-move monitoring activities. The format of some of the newer reports made it more difficult to determine whether or not all applicable sites had been monitored. However, in reading the narratives, the Post-Move Monitor had provided information about the sites visited and generally what was reviewed at the various sites. <u>Content of Checklists</u> Based on a review of 18 post-move monitoring reports, all (100%) were completed thoroughly. CCSSLC had used various forms to document its post-move monitoring activities due to changes State office had required. However, regardless of the form used, the Post-Move Monitor had continued to document the evidence to support her conclusions about the presence or not of pre- and post-move supports. 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. 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	Substantial Compliance

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		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. One issue that was identified was that sometimes the Post-Move Monitor had checked "No," when it appeared "N/A" was more appropriate, because a support was not yet due (e.g., for Individual #74, Individual #221, Individual #353, and Individual #355). These discrepancies were limited to a few supports, and might only become problematic if aggregate data were used to assess post-transition compliance with CLDPs, which the Facility was not currently doing. An important development had occurred related to a finding from the Monitoring Team's last report. Specifically, for individuals with complex needs, the Monitoring Team indicated it might be necessary for the Post-move Monitor to have input from staff with clinical expertise. Since the last review, the QA Nurse had been identified as a resource for the Post-move Monitor. Reportedly, the QA Nurse was available for consultation, as well as to go on visits, as needed. Although this resource had not been used yet, it was positive that the Facility had taken these steps to ensure the integrity of the post-move monitoring process. <u>Use of Facility's Best Efforts to Ensure Supports Are Implemented</u> 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 10 individuals reviewed, five of them had needs identified for which follow-up was necessary to ensure supports were implemented (i.e., Individual #71, Individual #353, Individual #221, Individual #26, and Individual #47). ▪ Of the five individuals for whom follow-up was indicated, documentation was present to show that for five (100%), sufficient follow-up had occurred. In most instances, it appeared that the Post-Move Monitor had taken a number of steps to follow-up, and these efforts appeared to be sufficient to correct the issues identified. In addition, for one individual (i.e., Individual #26), two team meetings were held. These meetings included the CCSSLC team, the community provider agency, and the individual's advocate. At these meetings, commitments were obtained from the provider agency to put missing post-move required supports in place, and persons responsible and timeframes for completion were established. Although not all issues raised in the first meeting were addressed by the time of the second meeting, it appeared that the provider generally responded to the team and advocate's intervention.	

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		The quality of the post-move monitoring visits and reports remained high. Since the last review, the Facility had made progress in involving at least one individual's team in the follow-up process, and effectively addressing issues identified through post-move monitoring activities. As a result, the Facility was found to be in substantial compliance with this provision. As a note of caution, as identified above, CLDPs were still missing many necessary supports. As improvements occur with the CLDPs, post-move monitoring activities and related follow-up will necessarily become more extensive. The Facility should ensure that it keeps pace with these changes in order to maintain its finding of substantial compliance.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #112. 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 #112'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 related to supports included in the pre- and post-move list on the CLDP. The Post-Move Monitor worked professionally with the provider staff to discuss these issues and potential solutions. For example, this included retraining staff on taking his blood pressure before administering one of his medications, and ensuring he remained upright for an hour after meals. Based on a review of the post-move monitoring report, it was thorough. The Post-Move Monitor had documented her findings, including relevant evidence that she reviewed, as well as follow-up activities in which she had engaged. Due to the thorough and accurate post-move monitoring observed, the Facility has been found in substantial compliance with this provision. As has been discussed, maintaining substantial compliance will require the Post-Move Monitor to keep pace with the expanded responsibilities for monitoring that will occur once CLDPs are improved.	Substantial Compliance
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		

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	criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment	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, one individual had transferred from CCSSLC to another SSLC (i.e., Individual #109). Based on a review of the discharge summary completed for Individual #109, 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 one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., court order requiring the transfer). ▪ **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, it could not be determined how much time was provided, but based on the fact that the Facility was operating under an order of the court, the team likely could not set the timeframe. As a result, the following indicator was not evaluated: for ___ out of ___ individuals (___%), reasonable time was given to prepare. ▪ **At the time of the discharge, the Facility develops a final summary of the**	Noncompliance

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	order.	**individual's developmental, behavioral, social, health and nutritional status:** Although the final summary included each of these components, for none of the one individual (0%) was the information adequate. 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 individual was receiving. For example, only the nutritional and medical summaries discussed current treatment. In addition, 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, the individual was described as having significant behavioral issues. However, the behavioral summary and the psychiatric summary were very general, and did not provide the receiving facility specific information about the individual's current status or which interventions were most 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 one individual (0%), CCSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. ▪ **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 one individual (0%) adequately described the key supports that the individual would need in his new setting. This section of the support simply stated: "[Individual #109] was present during a telephone conference with… SSLC. He had opportunity to ask questions regarding their facility, employment, and ability to maintain contact with his family. The IDT from [receiving SSLC] informed [Individual #109] that upon his arrival, several assessments would be completed and a plan will be developed for him." The information included in the other sections of the summary was largely assessment information or narratives regarding general status. No recommendations were included in the narrative in relation to continuing or modifying current supports, and a specific and comprehensive list of recommendations 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.	

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 DADS Policy #019: Guardianship, dated 3/7/12; o CCSSLC policies, including: ▪ Policy #UU.2 – Rights and Protection: Assigning Levels of Supervision, Implementation date 7/25/13; ▪ Policy #UU.3 – Rights and Protection: Ensuring Individual Rights, implementation date 6/7/13; ▪ Policy #UU.5 – Rights and Protection and Staff Conduct: Human Rights Committee (HRC) Member Recruitment Plan, implementation date 6/7/13; and ▪ Policy #UU.8 – Rights and Protection: Advocacy Program, implementation date 11/17/11 and draft revision, dated 7/23/13; 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 7/31/13; o In response to request for list of individuals for whom a Legally Authorized Representative (LAR) or Advocate was obtained: "No Evidence for File;" o Template for letter sent to family members who are not guardians before the annual ISP meeting with inserts; o Provider Fair flyer for event held 6/11/13; o Family Association flyer for event held 8/24/13; o Section U – Consent Monthly Reports from the QA Department, for the months of February 2013 to August 2013; o Membership and Affiliation of the CCSSLC Guardianship Committee, dated 8/31/13; o Guardianship Committee Minutes, for last six months; o Draft Guardianship Priority Discussion, dated 8/21/13; 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 9/13/13. 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 CCSSLC Guidelines for Section U Monitoring Tool: Section U – Consent Guidelines: o Based on interview with Facility staff, work had continued to refine the original Section U monitoring tool, including the addition of guidelines. According to the PCM and HRO, they had met to discuss inter-rater reliability results, and since the Monitoring Team's last review continued to make changes to the guidelines. Although these attempts to further define the criteria and methodology for monitoring were positive, until processes were in place to both assess individuals' functional capacity to make decisions and prioritize individuals' need for a guardian, finalizing these instructions/guidelines will be difficult. o In addition, in reviewing the Facility's Self-Assessment, it did not appear that any information from the monitoring activities were included. o In reviewing the QA Monthly Reports, the Facility had begun to look at the scores for each of the overall questions, which was good, but further breakdown will be needed, particularly once tools are available for the functional capacity assessment and prioritization of individuals' needs. 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 provide 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. In the monthly updates overall inter-rater reliability scores were provided, but details could be provided upon request of the scores per question. o As noted above, the Self-Assessment did not utilize data from these monitoring activities, but ultimately should. When such information is included in the Self-Assessment, it will be important 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. ▪ The monitoring tool and/or 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 referenced the Action Plans in place to achieve compliance with Section U. Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process 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 State 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." 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 previous two reports, 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 7/31/13. It included a total of 248 names. Of these, 155 individuals were identified as adults with no guardians, but needing guardians. This group included 41 individuals with a Level 1 priority need for guardianship (the highest level), 93 with Level II priority need, and 21 with Level III priority need. Another 89 individuals were identified as adults with guardians, and an additional four had no priority level for guardianship (i.e., these individuals appeared to be newly admitted to CCSSLC). The Facility recognized the need to use a more objective process to determine individuals' priority level in terms of their need for a guardian. As a result, CCSSLC had begun to draft a revised version of a rating tool obtained from another SSLC. Based on review of the Draft Guardianship Priority Discussion, dated 8/21/13, a number of questions arose. It will be important for the Guardianship Committee to better define objective (i.e., measurable) criteria, as well as to provide clear guidance to teams on the use of this tool, and in particular, its relationship with specific assessments. 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. The Facility's Guardianship Committee had continued to meet regularly. Since the last review, additional external members had joined the group, which was a positive step forward.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	Since the Monitoring Team's last review, no new DADS or CCSSLC local policies had been developed in relationship to consent or guardianship. CCSSLC had updated/revised some policies related to advocacy, the HRC, and rights, but not directly related to consent or guardianship. In 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." 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. In other words, without knowing through an objective assessment which individuals require guardians, any prioritized list of individuals is potentially inaccurate. 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 two reports, based on review of documentation provided at that time, a number of problems were noted with regard to the implementation of the process. These issues were detailed in the last two reports and are not repeated here. 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	Noncompliance

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		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. Based on this process, CCSSLC generated a prioritized list. The most recent one the Facility provided was dated 7/31/13. It included a total of 248 names. Of these, 155 individuals were identified as adults with no guardians, but needing guardians. This group included 41 with a Level 1 priority need for guardianship (the highest level), 93 with Level II priority need, and 21 with Level III priority need. Another 89 individuals were identified as adults with guardians, and an additional four had no priority level for guardianship (i.e., these individuals appeared to be newly admitted to CCSSLC). The Facility recognized the need to use a more objective process to determine individuals' priority level in terms of their need for a guardian. As a result, Facility staff had obtained a tool another SSLC used, and had begun to draft a revised version for CCSSLC. At the time of the onsite review, a draft was provided to the Monitoring Team, but the Guardianship Committee still needed to review it. Based on review of the Draft Guardianship Priority Discussion, dated 8/21/13, a number of questions arose, including, but not limited to: ▪ It was not clear exactly how this tool would be used in concert with the Rights Assessment. For example, although the Rights Assessment was referenced in the section for "Need for decisions requiring consent," it was unclear if each area of decision-making listed in the Rights Assessment needed to be scored using the scoring methodology included in the first section related to "Ability to express wishes or make determinations regarding health or welfare." ▪ The scoring criteria were generally very broad, and left considerable room for interpretation. As just a few examples, the following criteria likely would be interpreted differently by different teams: "The person requires a high level of assistance in this area, or the person is unable to make decisions in this area," or "Needs in these areas significantly hinder independence, functioning, and/or quality of life of this person." It will be important for the Guardianship Committee to better define objective (i.e., measurable) criteria, as well as to provide clear guidance to teams on the use of this tool, and in particular, its relationship with other assessments. 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	

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		informed decisions, or increase their capacity to make such decisions. CCSSLC was working on some alternatives to guardianship and/or resources to assist individuals in making their own decisions. For example, the following valuable activities were ongoing: ▪ One such support is the assignment of an advocate. Teams at CCSSLC continued to discuss this as an option. Since the last review, the HRO had drafted and the Guardianship Committee had reviewed and approved a mechanism to track individuals whose teams had recommended an advocate. At the time of the review, a list of approximately 15 to 20 individuals had been generated. As discussed in further detail with regard to Section U.2, the HRO was continuing to develop contacts that might be helpful in identifying volunteer advocates for individuals needing them. ▪ In response to a Plan of Correction required as a result of the regulatory process, the Facility had begun to develop some easy-to-understand materials on individuals' rights and, importantly, their responsibilities. Training had begun for both staff and individuals. ▪ The Human Rights Officer continued as 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, 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-friendly manner, etc.). Although not a requirement of the Settlement Agreement, it was positive that staff from CCSSLC had attended training from a consultant group entitled: "Human Rights Committee Functions and Responsibilities." A portion of this training discussed the concept of informed consent. The Facility remained out of compliance with this component of the Settlement	

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		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 Facility staff were working to develop more objective criteria to determine an individual's priority level for guardianship, more work was needed to develop observable, measurable criteria 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, the HRO had met with the clerk of the local court with responsibility for guardianship proceedings, which was a good relationship to develop. ▪ Since then, a list had been developed of local attorneys that could assist interested people in petitioning the court for guardianship. Staff updated this list by calling the offices of local attorneys to confirm that guardianship proceedings were part of their practice. Facility staff could not make recommendations about specific attorneys. However, the list provided options that interested parties could investigate on their own. One of the attorneys was scheduled to conduct training on the legal aspects of guardianship at an upcoming Guardianship Committee meeting. ▪ As mentioned briefly above, the HRO had begun to have some discussions with local churches about potential volunteer opportunities, including as volunteer advocates or guardians for individuals at CCSSLC. ▪ 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 nonprofit guardianship entities to which referrals could be made. ▪ 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 Living Center," and "Guardianship Process in Texas." For ISP meetings scheduled for October 2013, the list of attorneys that could assist with guardianship had been added. The Facility had included in the cover letter information about the fact that individuals' funds could be used to cover the	Noncompliance

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		costs of guardianship. ▪ State Office reportedly was working on a brochure to provide information about the need for and roles and responsibilities of volunteer advocates and guardians. Once finalized, the CCSSLC HRO's name and contact information could be added on a sticker on the back. ▪ In August 2013, the Human Rights Officer attended a Family Association Meeting. ▪ In June 2013, the Human Rights Officer attended the Provider Fair. It was anticipated that at an upcoming Provider Fair, the Self-Advocacy Group would run a booth and distribute information on guardianship and consent as it had done in October 2012. ▪ As noted in the Monitoring Team's previous report, the Facility continued to implement an advocacy program. This involved the recruitment of volunteers to serve as individuals' advocates. This potentially provided a resource to assist individuals in decision-making that was less restrictive than guardianship. Since the last review, based on guidance from State Office, the Facility policy had been modified to clarify that staff could not act as individuals' formal advocates, due to the potential for a conflict of interest. However, they could be assigned as individuals' "Special Friends." As noted in the last report, CCSSLC had begun to implement the portion of the State Office Guardianship policy that required development of a Guardianship Committee. At the time of the previous review, the Committee consisted mostly of members of the CCSSLC staff, but an HRO from one of the Local Authorities recently had become a member. Since then, two additional external members had become members of the Committee. It was positive that the Committee membership was broad. This 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. As noted in the last report, 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 was recommended that the Guardianship Committee develop and implement a more	

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		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 with regard to Section U.1, although staff had made some efforts to develop such a tool, more work was needed to ensure it was an objective process that could be implemented consistently across teams. As noted above, the current list of individuals potentially requiring guardians included 155 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. 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.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Persons Responsible for Management of Records; o Description of Quality Assurance Procedures; o Minimum Documents included in Master Record, dated 1/21/13; o Master Record Order and Guidelines: Historical Records revised 11/19/10; o Master Record Order and Guidelines: Active Records Purged from Units, revised 3/10/11; o Master Record Order and Guidelines: Inactive Records, revised 3/10/11; o Active Record Order and Guidelines, dated 4/5/13; o Individual Notebook and Guidelines, revised 5/17/13; o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; o Section V Corrective Action Plan, dated 6/14/13;List of all new and revised policies implemented since the Monitoring Team's last review; o Record audit with revised guidelines, revised September 2013; o Samples of recent audits and aggregate data and graphs; o Competency Training Development 2013 CCSSLC Policy and Training Update; o Draft PowerPoint for training on policy development; 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; o Blanca Goans, Administrative Programs Specialist; and 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. However, as discussed with regard to Section V.3, the Facility had developed instructions for the audit tool, but the criteria used called into question the validity of the results. The Facility had established 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 of the data will be important next steps. In addition, it will be important to use 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' had been converted to a revised Table of Contents that State Office issued. 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 the time of the last review, a method was being developed to accurately track staff's training on policies. At the time of this most recent review, the Competency Training Department had a process to for tracking the completion of training, and was able to send reminders to staff who had not yet completed the training. The Administrative Programs Specialist also assisted with training follow-up, and reported the training status to the QA/QI Council. CCSSLC was conducting the required five records each month. A Program Compliance Monitor from the QA Department also involved in the process. While the Monitoring Team was on site, the Unified Records Coordinator modified the spreadsheet used to collect data on the audits. With these modifications, the very specific information collected about each record reviewed could be aggregated. This should significantly assist in trending the data and identifying issues that specific disciplines or residences might need to address, or for which the Facility might need to develop and implement more systemic actions.

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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.	Based on documentation, as well as staff report, as of 8/31/13, all individuals' Active Records had been converted to a revised Table of Contents that State Office had issued. According to staff, one of the goals of the new Table of Contents was to standardize the names of documents, so that all records throughout the system included similar information. The Records Department had created a summary of the changes to make it easier for staff in the various disciplines. The changes also were presented to the QA/QI Council. 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, and reportedly, all Individual Notebooks were in place. As reported previously, 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.	Noncompliance

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		As reported in the Monitoring Team's last report, the Medical Records Coordinator had completed the conversion of the Master Records. In 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 the Monitoring Team's limited review of records while on site, it was noted that very few documents were missing from the records. However, based on information presented at the QA/QI Council the Monitoring Team observed while on site, internal record reviews had identified missing assessments from the records. A group was formed to address this issue. As noted in the previous reports, 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 previous 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 step towards compliance with this provision was using the information from its audits to identify and address issues related to the quality of the records. As discussed while the Monitoring Team was on site, Appendix D requirements are a key component of substantial compliance with this provision. As is discussed in further detail with regard to Section V.3, the Facility had data that showed where some of the quality issues were. During the week of the onsite review, the Unified Records Coordinator made impressive changes to spreadsheet used to collect audit data. These modifications allowed the aggregation of this data across disciplines as well as residential sites. It will be important over the coming months to use this data to identify trends, and take actions to correct them. The Facility continued to make progress in this area. Since the last review, the Active 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	

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		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 appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	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 three reports, the Facility had developed a system to track draft policies through to finalization. The QA/QI Council was responsible for approving policies, and based on proposals from the authors of policies, decisions were made at QA/QI Council about who needed to be trained, who would provide the training, and the curriculum used. At the time of the last review, a method was being developed to accurately track staff's training on policies. At the time of this most recent review, CTD had a process to for tracking the completion of training, and was able to send reminders to staff who had not yet completed the training. The Administrative Programs Specialist also assisted with training follow-up, and reported the training status to the QA/QI Council. A document entitled: "CTD – 2013 CCSSLC Policy Training Tracking" provided a summary of the status of training, including the number of people trained (n) in comparison with the number of people needing training (N). Based on this summary, close to 100% of staff had been trained on recently released policies. These were significant positive developments. The Facility had revised its Policy A.13: Policy Review, Training and Implementation, implementation date of 4/4/13. Discipline Leads had requested training on the policy process. At the time of the review, a PowerPoint training module was in draft format. Based on review of the draft, it appeared it would be helpful and keep people's attention. In addition to providing a simple explanation of the current policy process, it explained that policies would be reviewed annually and updated if appropriate, which was one of the next steps in which the Facility was engaging. 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 that require training on the policies complete the training adequate to facilitate the policies' implementation.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ The Unified Records Coordinator was conducting record reviews. ▪ Based on the documentation provided, it appeared that five reviews were being	Noncompliance

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	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.	conducted each month. ▪ An Individual Notebook Audit had been developed and was being implemented. ▪ 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. ▪ 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." ▪ As of July 2013, inter-rater reliability was estimated at 88% between the Section Lead and the PCM. Efforts had been made to conduct record reviews on the same day to prevent differences due to changes in the records. ▪ As reported in the past, 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. ▪ While the Monitoring Team was on site, the Unified Records Coordinator modified the spreadsheet used to collect data on the audits. With these modifications, the very specific information collected about each record reviewed could be aggregated. This should significantly assist in trending the data and identifying issues that specific disciplines or residences might need to address, or for which the Facility might need to develop and implement more systemic actions. ▪ A CAP had been developed to address missing signatures and dates. This CAP was still in the implementation phase during the onsite review. Areas in which improvements should be made in order to achieve compliance, included: ▪ Since the last review, the Facility modified the standards it used for assessing the quality components of the records related to Appendix D of the Settlement Agreement. As discussed while on site, the Facility is encouraged to review these to ensure that they are sensitive enough to pick up potential issues. As the Monitoring Team understood it, each section of the record would be assessed separately (e.g., IPNs, observation notes, assessments, etc.), and if discrepancies (e.g., legibility, missing signatures, etc.) were found, then the section was marked as noncompliant. Then, if six sections within the same record were found to be noncompliant, the record would be counted as noncompliant for that particular qualitative component. This appeared to allow for too much variability in quality to provide valid results.	

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		▪ 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 in the process. 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. A corrective action plan had been developed and was in the process of being implemented. However, more specific plans likely would be needed once more extensive analysis was completed. 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. 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	Noncompliance

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		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. Efforts were being made to speak with different staff, and track which staff already had participated in this exercise. ▪ **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.	

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
CAP	Corrective Action Plan
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
CIRP	Crisis Intervention Restraint Plan
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
CPA	Comprehensive Psychological Assessment
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
QIDP	Qualified Intellectual Disabilities Professional
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SA	Speech Assistant
SAC	Settlement Agreement Coordinator
SAMS	Self-Administration of Medication
SAO	Skill Acquisition Objective
SAP	Skill Acquisition Plan
SARC	Skill Acquisition Review Committee
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
SPCI	Safety Plans for Crisis Intervention
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