United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: April 28-May2, 2014

Date of Report: June 19, 2014

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Table of Contents

Background

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

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

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

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

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

Methodology

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

(a) **Onsite review** – During the week of the review, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for offsite 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 onsite. 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 onsite, 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, Interdisciplinary Team (IDT) meetings, discipline meetings, incident management meetings, and shift change.

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

Organization of Report

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

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

Substantial Compliance Ratings and Progress

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

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

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

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

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

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal to the Monitor and DOJ for review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

The monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SASSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Ralph Henry, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement.

The Settlement Agreement Coordinator, Andy Rodriguez, did a great job, before, during, and after the onsite review. He ensured that the monitoring team received documents, he assisted with scheduling, and played an important role in the QA program at SASSLC. The work of his assistant, Nercy Navarro, was also appreciated by the monitoring team.

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

Restraint

- There were 43 restraints used for crisis intervention involving 10 individuals between 10/1/13 and 3/1/14. The number of restraint incidents had increased since the last onsite review when there had been 25 restraints. Individual #304 accounted for 14 of the 43 (33%) restraints used for crisis intervention. The three individuals with the greatest number of restraints accounted for 56% of the total restraints. It was not evident that least restrictive interventions were considered or attempted prior to the use of chemical restraint.
- There were 93 instances of dental/medical restraint from 10/1/13 through 3/31/14. There was no evidence that IDTs were adequately discussing risks associated with the use of pretreatment sedation or general anesthesia related to risk factors identified for each individual (i.e., drug interactions, cardiac issues, osteoporosis, aspiration risk).
- The facility reported that 10 individuals at the facility wore protective mechanical restraints (PMRs) for self-injurious behaviors. The facility had developed protective mechanical restraint plans for those individuals.
- To move forward, the facility should continue to focus on:
    - Ensuring that restraint documentation clearly describes behavior that led to the restraint and documents all interventions attempted prior to the use of restraint.
    - Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines.
    - Ensuring that restraints used to complete routine dental exams are the least restrictive intervention necessary and that less restrictive interventions have been considered or attempted.
    - Ensuring that IDTs engage in a thorough discussion regarding the risk associated with completing routine exams using pretreatment sedation for each individual.
    - Ensuring that all employees receive annual training within the required timelines.

Abuse, Neglect, and Incident Management

- Of 119 allegations, there were six confirmed cases of abuse and 11 confirmed cases of neglect. The facility reported that 38 other serious incidents were investigated by the facility during this period.
- There were a total of 1390 injuries reported between 9/1/13 and 2/28/14. These 1390 injuries included 26 serious injuries resulting in fractures or sutures.
- The incident management department was preparing data reports for the monthly QA/QI unit meetings regarding injuries and injury trends. It was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents.
- 50% of the DFPS investigations were not completed within 10 calendar days of the incident being reported. There was not sufficient evidence that the delay was because of extraordinary circumstances in the investigations not completed in a timely manner.

- The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring.
- The facility was still not adequately developing action plans to address trends of injuries and incidents.

Quality Assurance

- There were eight deaths in the past six months. This serious outcome was not picked up by any of the items in the inventory, QA matrix, or QA reports indicating problems in the collection and monitoring of data at the facility.
- Of the 16 data list inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 2 (13%) included a wide range of data that appeared to cover all aspects of the discipline and Settlement Agreement; 14 (88%) included what appeared to be key indicators; 16 (100%) described the data being collected; and 7 (44%) included a self-monitoring tool.
- The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council.
- In the last six months, a facility QA report was created for six of the last six months (100%). There should be an analysis of the causes of the problem, not just a description of their occurrence.
- Continued work was done to improve the CAPs system. One of the program auditors spoke with each person responsible for an open CAP every week. There was, however, no criterion to judge when/if the overall CAP was being met.
- The QAD director was just initiating a very creative and important activity to reviewing 40% of all closed CAPs to see if the corrections were maintained and the issues for which the CAP was created remained at a satisfactory level.

Integrated Protections, Services, Treatment, and Support

- The facility had made little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits.
- Two annual ISP meetings and two pre-ISP meetings were observed during the monitoring visit. Many improvements were noted in regards to facilitation skills and interdisciplinary discussion.
- There was little discussion at either meeting, however, regarding how the individual spent a majority of his or her day or how the team would ensure that they were involved in meaningful activities.
- The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. Very few revisions were made to current supports with little consideration of whether or not the support had been effective. IDTs were unable to determine the status of current supports due to a lack of documentation and consistent monitoring of services.

- All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

Integrated Clinical Services

- No true progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services. However, some meetings were expanded or included more discussions that had the potential to improve integration of clinical services.
- The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. He reported on integration activities, but the discussion was limited to the meetings of the disciplines.

Minimum Common Elements of Clinical Care

- There was minimal progress observed in this provision.
- The facility continued to track assessments centrally. Each department also tracked assessments. There was no information available on the quality of assessments and tools had not been developed. Interval assessments were not addressed.
- The facility continued its Medical Quality Improvement Committee and much of section H was linked to data derived from that committee. Progress in the medical quality program will likely translate into progress in section H because much of section H is about quality.

At-Risk Individuals

- The parties agreed that the monitoring team would conduct reduced monitoring for I1, I2, and I3 because the facility had made little progress.
- The monitoring team observed the risk identification process at two ISP meetings and noted progress. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF.
- The facility continued to struggle, however, with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings.
- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs.

- Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

Psychiatric Care and Services

- SASSLC was in substantial compliance with two provisions in this section. Since the last monitoring visit, there had been challenges due to a turnover in psychiatric clinic staff. Currently, 65% of the facility population (154 individuals) was receiving services via psychiatry clinic. There was a paucity of combined assessment and case formulation as only 46% of comprehensive psychiatric evaluations per Appendix B had been completed. The evaluations completed, however, were of general good quality.
- The monitoring team observed two psychiatric clinics. There was participation in the discussion and collaboration between the disciplines (psychiatry, behavioral health, nursing, QIDP, direct care staff, and the individual).
- During this monitoring period, the facility had made changes to the manner in which additional medications (i.e., chemical restraints) were categorized. The facility reported a total of three chemical restraints during this monitoring period. There were an additional 16 medication administrations that were categorized as PEMA (psychiatric emergency medication administration). Given this change in category, these administrations were not subjected to post emergency restraint review processes. There was currently no policy and procedure in effect to define this practice or to outline the procedures that must be followed.

Psychological Care and Services

- SASSLC maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements included implementation of a new more flexible, individualized data collection system; improvement in data collection timeliness; and improved accessibility of data sheets to the DSPs. There was evidence of consistent data-based treatment decisions, increased number of replacement behavior graphs, and evidence of consistent action recommended in the progress notes when individuals were not making expected progress. There were also improvements in the assessment of treatment integrity of PBSP implementation.
- The areas that the monitoring team suggests that SASSLC work on for the next onsite review are to ensure that replacement behaviors are consistently included in the new data collection system and are consistently graphed. The facility should reinitiate the collection of data timeliness and IOA data, ensure that all functional assessments have the correct use of terminology, ensure that counseling services treatment plans/progress notes are consistently complete, and ensure that each PBSP contains a functional replacement behavior, or an explanation why a functional replacement behavior is impossible or impractical. Also, levels and frequencies of treatment integrity should be established and then achieved.

Medical Care

- Some services, such as immunizations, were provided with high rates of compliance and improvement was seen in the compliance with vision screenings. However, compliance with many cancer screenings was poor based on record reviews. Individuals were identified through record reviews who were never assessed by a physician for acute medical problems, but should have been.
- Record and document reviews indicated that access to some specialty care was either not adequate or was not being appropriately utilized. The facility did not maintain any data to demonstrate timeliness of appointments.
- The facility had a relatively high incidence of pneumonia. It was concerning that there had been no additional review of this trend. Similarly, there were numerous individuals hospitalized with bowel associated issues, such as bowel obstruction, ileus, and constipation.
- As noted in previous reviews, the facility submitted no justification for the DNRs. In fact, the table submitted appeared to include the same outdated data submitted for the October 2013 review.
- There were eight deaths since the last compliance review and 75 percent of the deaths involved the diagnosis of pneumonia. During the customary mortality management discussion, it was reported that the facility had taken a critical look at all deaths and there were no unusual findings. It was also reported that state office was reviewing deaths and providing recommendations, but had none for SASSLC.
- Some components of this review were hampered by the lack of accurate data. The medical department cannot measure its own progress if it cannot collect and report data accurately. Establishing a standardized set of quality measures, collecting and reporting data, is a required component for any health care delivery system.
- In addition to problems with data accuracy, the facility also appears to have problems maintaining documents and records. An individual experienced an adverse outcome associated with anesthesia. The documents containing the information central to this case were reported as "nowhere to be found."

Nursing Care

- Progress was made in most areas. Substantial compliance was achieved for provision M6. The CNE established and strengthened standing operational guidelines and expectations for accountability and performance of nursing staff. Nursing Audits were improving, but were not consistently trending upward.
- There was improvement in timely assessments and timely notification to physicians for individual's health care problems, including following their own emergency procedures for emergency health issues. The Nursing Department had been proactive in addressing skin integrity issues through a partnership with external hospital nursing staff that included an exchange of each other's expertise with pressure ulcers.
- The facility's Infection Control Preventionist was more visible on the homes and had taken lead role in trying to minimize the spread of infections through daily surveillance rounds and attending the morning meetings. However, given the number of infections and cases of pneumonia, the facility should intensify its infection control efforts.

- The collection and validation of immunization data needed revamping in order to consistently have on day to day basis availability, the immunization/immunity status of individual who reside at SASSLC.
- Most progress had been made in all aspects of medication administration practice in accordance with generally accepted standards of practice. The facility had improved on tracking and analyzing medication variances, including taking actions that resulted in system changes.

Pharmacy Services and Safe Medication Practices

- Medications for SASSLC continued to be dispensed at the San Antonio State Hospital (SASH). This presented a unique set of challenges for the facility. The SASSLC long-term clinical pharmacist remained in the role as pharmacy lead.
- While SASH had implemented the Intelligent Alerts, the system of documentation did not clearly identify them in the notes extracts. This was very different from the findings of the October 2013 compliance review when numerous Intelligent Alerts were documented, but rejected by the medical staff.
- The QDRRs were done within the required timeframes and for the most part were adequately completed.
- The facility developed a Performance Improvement Team to address the barriers related to completion of the MOSES and DISCUS evaluations. This appeared to have a favorable impact on completion of the evaluations.
- A modified Hartwig severity scale was implemented and a threshold was set to determine when additional reviews of ADRs were required. The threshold was met twice, but the facility had not established a format for completing the reviews.
- DUEs were completed as required and the evaluations included the necessary components. The clinical staff must exercise caution in how they use the results of the DUEs. The findings of both DUEs were used to make generalized statements, but these were inconsistent with the medical literature.
- During the October 2013 review, the medication variance program was described as being in a state of disarray. Overall, there was improvement, but it was somewhat limited. While it appeared that medication variances decreased, the significance of the decrease was not clear because the facility lost the ability to reconcile medications upon return to the SASH pharmacy.
- Documentation for the Pharmacy and Therapeutics Committee must be addressed.

Physical and Nutritional Management

- Gains were made across all sections. There was a fully dedicated PNMT with the dietitian as the one new member. They continued to refine their processes and documentation. The evaluation was much improved over previous visits, though work was still needed with regard to the analysis.
- Positioning looked much improved, though this was an area that requires ongoing diligence to maintain staff competence and compliance. Mealtimes on three homes that had issues in previous visits were again observed. Homes 673 and 674 were excellent. Staff were efficient in the delivery of the meals, accurate in implementation of the Dining

Plans, and interactive with individuals. No errors were observed. There continued to significant concerns in home 670. There was a clear lack of leadership and oversight.

- Some areas of continued need for improvement are:
  - Recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs.
  - More consistent use of the ISPA process with clear documentation is encouraged.
  - Clarification of the staff who had successfully completed all competency-based training was needed.
  - Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency.
  - Ensure that ISPAs are held to address changes in status and changes in supports and services.
  - Establish protocol related to the completion of assessments, especially related to nutrition evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition.

<u>Physical and Occupational Therapy</u>

- OT/PT assessments continued to improve. Substantial compliance with P.1 was maintained and achieved for P.3. The assessment essential element section should be carefully reviewed so that content of some elements can be further refined. Further integration of OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA.
- The therapists spent a considerable amount of time looking at individuals in a creative manner and were proud to show off what they had accomplished over the last six months. They were clearly working collaboratively with other team members to arrive at effective solutions.

<u>Dental Services</u>

- There were a number of positive findings during this review. Individuals received timely annual assessments and were scheduled for necessary treatments. Treatment required consent and the extended delays related to the consent process and HRC approval continued to decrease. A policy detailing the facility's guidelines for obtaining radiographs was developed and approved.
- Oral hygiene continued to be a significant problem for the facility. More than 30 percent of individuals maintained poor hygiene status.
- TIVA was another major concern. The use of intravenous anesthesia requires careful selection and monitoring of individuals. Procedures did not adequately address perioperative evaluation. Moreover, the documents reviewed by the monitoring team provided no evidence of the appropriate post-anesthesia monitoring.
- Refusals were incorrectly recorded. Only those individuals who refused to go to clinic were documented as refusals.

Communication

- There was continued, steady progress in all aspects of provision R and substantial compliance was achieved in R.2. Assessment quality and timeliness had improved and efforts to improve the content of communication assessments were evident. Additionally, there had been a clear effort to work collaboratively with behavioral health to develop communication strategies that were well-integrated into the PBSP and throughout the daily routine.
- There were a tremendous number of communication systems in place, including many communication SAPs, though integration of communication supports was not consistently integrated into the ISPs.
- Sections from the communication assessment were inserted into the ISP. This must include actual documentation that the IDT reviewed the communication dictionary, communication plans, and supports, and that the IDT specifically identified the effectiveness and any need for changes.
- The facility continued to struggle with focusing on what was most meaningful and what were the most fundamental needs of the individual with consistent implementation of SAPs and group activities based on these. Success with this will, in part, require that the speech clinicians lend their creativity by participating on a routine basis to model and infuse communication behavior and interactions in a meaningful way.

Habilitation, Training, Education, and Skill Acquisition Programs

- There were several improvements since the last review. These included improvements in the quality of SAPs reviewed. Individualized targeted engagement levels were achieved in 52% of treatment sites in March 2014. The facility initiated dental desensitization plans, improved the engagement tool, increased percentage of graphed SAP data, and developed program change forms to document data-based decisions to continue, discontinue, or modify SAPs. There was an expansion of the collection of SAP treatment integrity data to the residences, development of a public transportation assessment, and establishment of individualized recreational and community training goals for all residences.
- The monitoring team suggests that the facility focus on the ensuring that all SAPs contain clear examples of all the components necessary for learning discussed in the report. The facility should develop a system (e.g., spreadsheet) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams. Further, the facility should ensure that SAP treatment integrity includes a direct observation of DCPs implementing the plan, establish acceptable treatment integrity levels, and demonstrate that established goal levels of individuals participating in community activities and training are achieved.

Most Integrated Setting Practices

- Progress continued. Given that the APC had completed her first six months in this position, the department was only recently fully staffed, and many individuals were placed and referred, it was not surprising that only limited progress was seen in the many procedural requirements of section T. Ten individuals were placed in the community since the

last onsite review. 29 individuals were on the active referral list. Of the 23 individuals who moved in the past 12 months, 2 had one or more untoward events that occurred within the past six months (15%).

- Systemic issues were identified that competed with referrals and transitions. These were noted to be lack of community provider expertise in supporting individuals with complex behavioral and psychiatric needs, availability of community psychiatrists, absence of adequate day and employment programs, and provider challenges in creating accessible housing.
- CLDPs were much improved compared with previous reviews. Lists of pre- and post-move supports contained a wider range of supports than ever before. Discharge assessments, however, were not designed around the individual's upcoming move and new residential, day, and/or employment settings.
- Post move monitoring continued to be implemented as required and maintained substantial compliance. 29 post move monitorings for 13 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed-up when action was needed.
- Post move monitoring was observed by the monitoring team. The individual was reported to have exhibited problem behaviors at the apartment complex and the provider was unable to successfully deal with these. State office was notified following the post move monitoring visit.

Guardianship and Consent

- This provision received no monitoring based upon the parties' agreement due to limited or no progress.

Recordkeeping Practices

- SASSLC made progress in some areas of section V and maintained status in other areas. Fourteen of 14 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions.
- The status of the active records maintained since the last review. There were about 10 errors/missing documents per active record, plus there were errors in legibility, signatures, etc. The most frequently missing documents were quarterly medical summaries, SAP progress notes and data sheets, and ISP monthly reviews.
- A master record existed for every individual at SASSLC and all were in a format that was organized, manageable, and described in previous reports. The CUR had not continued to implement the system of making entries onto the blue page to indicate what efforts had been taken to obtain any missing documents.
- Five quality assurance audits were done in five of the past six months. Beginning in February 2014, the URC began using the new 16-page tool that she developed. It incorporated the previous table of contents tool and statewide tool.
- The URC summarized her data in her monthly QA report. These data were inadequate in providing an understanding of the status of the unified record and setting the occasion for analysis and actions. Further, there was no analysis of the data that were being summarized.

Status of Compliance with the Settlement Agreement

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

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints #00.1
o SASSLC Self-Assessment
o SASSLC Provision Action Information Log
o SASSLC Section C Presentation Book
o Restraint Trend Analysis Reports for the past two quarters
o Section C QA Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o Restraint Reduction Committee minutes for the past six months
o List of all restraint monitors and date training was completed
o List of all restraint by individual in the past six months
o List of all chemical restraints used for the past six months
o List of all medical restraints used for the past six months
o List of all restraints used for crisis intervention for the past six months
o List of all mechanical restraints for the past six months
o List of all individual that were restrained off the grounds of the facility
o List of all injuries that occurred during restraint
o SASSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans
o List of individuals for whom pretreatment sedation was used to complete routine medical and dental exams.
o Sample #C.1: 10 records of physical restraints used in a crisis intervention for eight different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual’s Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint incidents in the sample were:
<table>
<tr><th>Individual</th><th>Type of Restraint</th><th>Date</th></tr>
<tr><td>#304</td><td>Physical</td><td>12/23/13 @ 1:20 pm</td></tr>
<tr><td>#304</td><td>Physical</td><td>11/22/13 @ 7:25 am</td></tr>
<tr><td>#39</td><td>Physical</td><td>1/10/14 @ 8:33 am</td></tr>
<tr><td>#39</td><td>Physical</td><td>1/10/14 @ 7:10 am</td></tr>
<tr><td>#95</td><td>Mechanical</td><td>11/6/13 @ 4:15 pm</td></tr>
</table>
</td></tr>
</table>

#16	Physical	10/24/13 @ 3:43 pm
#285	Physical	12/28/13 @ 7:53 pm
#3	Physical	11/11/13 @ 11:45 am
#225	Chemical	9/6/13 @ 2:00 pm
#247	Chemical	1/23/14 @ 10:55 am

- Sample #C.2 was documentation for a selected sample of 24 staff:
  - their start dates,
  - the dates they were assigned to work with individuals,
  - their training transcripts showing date of most recent:
    - PMAB training and
    - Training on the use of restraint.

- Sample #C.3 was a sample of documentation for pretreatment sedation chosen from the last ten medical/dental restraints including the physicians' orders for the restraint, including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any desensitization plan.

Individual	Restraint type
#204	2/19/13
#240	2/14/14
#88	2/25/14
#32	2/25/14
#188	2/13/14

- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was three.

Individual	Date
#225	9/6/13
#247	1/23/14

- Sample #C.5: Was selected from a sample of restraints that occurred off-campus. There were none.

Individual	Date

- Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
  - PBSPs, crisis intervention plans, and individual support plan addendums (ISPAs) for Individual #304 and Individual #39

- Sample #C.7 was chosen from the list of 11 individuals subjected to mechanical restraints for self-injurious behavior.

Individual	
#127	PMRP dated 10/23/13
#342	PMRP dated 2/20/14
#199	PMRP dated 3/17/13
#277	PMRP dated 1/15/14

Interviews and Meetings Held:

- Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs;
- Charlotte Fisher, Director of Behavioral Services
- Adrianne Berry, Incident Management Coordinator
- Rhonda Sloan, QIDP Coordinator
- Joan O'Connor, Assistant Director of Programming

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 4/28/14 and 4/29/14
- Morning Unit Meeting 5/1/14
- Morning Clinical Meeting 4/28/14
- ISP preparation meeting for Individual #255 and Individual #12
- Annual IDT Meeting for Individual #337 and Individual #90

Facility Self-Assessment:

SASSLC submitted its self-assessment. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale.

The Director of Behavioral Services was responsible for the self-assessment process. She engaged in a self-assessment process that included a review of a sample of restraints, training documentation, ISPs, and other IDT documents regarding the use and review of restraints, and data collected by the facility regarding restraints.

The facility assigned a self-rating of substantial compliance to C1, C2, C3, C5, C7, and C8. The monitoring team agreed with the facility's substantial compliance ratings for C2, C7, and C8. Many of the same problems noted during the last review continue to contribute to the monitoring teams rating of noncompliance including monitoring of restraints, post restraint assessment, and staff training.

	Summary of Monitor's Assessment: Based on a list of all restraint data provided by the facility, there were 43 restraints used for crisis intervention involving 10 individuals between 10/1/13 and 3/1/14. The number of restraint incidents had increased since the last onsite review when there had been 25 restraints during the review period. Individual #304 accounted for 14 of the 43 (33%) restraints used for crisis intervention. The three individuals with the greatest number of restraints accounted for 56% of the total restraints. Restraint data provided by the facility included 93 instances of dental/medical restraint from 10/1/13 through 3/31/14. There was no evidence that IDTs were adequately discussing risks associated with the use of pretreatment sedation or general anesthesia related to risk factors identified for each individual (i.e., drug interactions, cardiac issues, osteoporosis, aspiration risk). Furthermore, it was not evident that least restrictive interventions were considered or attempted prior to the use of chemical restraint. The facility reported that 10 individuals at the facility wore protective mechanical restraints (PMRs) for self-injurious behaviors. The facility had developed protective mechanical restraint plans for those individuals. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C. Observations in the homes and day programs and interviews with staff were conducted the week of the monitoring visit to gain additional information. Although the facility remained out of compliance with five of eight provision items in section C, some progress towards compliance had been made in regards to documentation and review of crisis intervention restraints. To move forward, the facility should continue to focus on: • Ensuring that restraint documentation clearly describes behavior that led to the restraint and documents all interventions attempted prior to the use of restraint. • Ensuring that nursing reviews for all restraint incidents are completed and appropriately documented following state policy guidelines. • Ensuring that restraints used to complete routine dental exams are the least restrictive intervention necessary and that less restrictive interventions have been considered or attempted. • Ensuring that IDTs engage in a thorough discussion regarding the risk associated with completing routine exams using pretreatment sedation for each individual. • Ensuring that all employees receive annual training within the required timelines.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.</td><td>According to restraint trend reports provided by the facility,

<table>
<tr><th>Type of Restraint</th><th>April 2013-Sept 2013</th><th>Oct 2013-Mar 2014</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>19</td><td>34</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>6</td><td>3</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>6</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>25</td><td>43</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>8</td><td>10</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>6</td><td>3</td></tr>
<tr><td>Medical/dental restraints</td><td>50</td><td>93</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>43</td><td>Not provided</td></tr>
<tr><td>Protective mechanical restraints</td><td>8</td><td>11</td></tr>
</table>

The monitoring team identified 16 additional instances where chemical restraint was administered for behavioral crisis intervention. The facility and state categorized these as psychiatric emergency medication administrations, however, the monitoring team considered these to fall under the category of chemical restraint. Moreover, a recent change to the state's policy definition of chemical restraint took that definition out of line with the definition of chemical restraint that is in the Settlement Agreement. These additional restraints were not documented or monitored as required by the state policy, therefore, it was not possible to determine if the restraints met the requirements of C1 including:
• A graduated range of less restrictive measures has been exhausted or ruled out in a clinically justifiable manner.
• The restraint was not used for punishment or the convenience of staff.
• The restraint was not used in the absence or as an alternative to treatment.

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

b. Based on review of other documentation (list of all restraints between 10/1/13 and 2/28/14) prone restraint was not identified.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 10/1/13 and 3/15/14. Sample #C.1 was a sample of 10 restraints for eight individuals, representing 23% of restraint records over the last six-month period and 80% of the individuals involved in restraints. The sample included seven physical restraints, two chemical restraints, and one mechanical restraint. Sample #C.1 included three individuals with the greatest number of restraints, as well as five individuals who were subject to some of the most recent application of restraints. c. Based on a review of the restraint records for individuals in Sample #C.1 involving eight individuals, zero (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> 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 10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • g. For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that eight (80%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. o Restraint checklists for Individual #39 dated 1/10/14 and Individual #285 dated 12/28/13 did not describe events leading to the restraint. It was not possible to determine the circumstances of the restraint. o Overall, descriptions of the circumstances leading to restraint were poorly documented on restraint checklists by staff involved in the restraint. Restraint monitors were clarifying information on the post restraint assessment. DSPs should clearly document events leading to the restraint on the restraint checklist. • h. In nine of the records (90%), 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. The exception was a chemical	

#	Provision	Assessment of Status	Compliance
		restraint for Individual #247 dated 1/23/14 • i. Facility policies identified a list of approved restraints. • j. Based on the review of 10 restraints, involving eight individuals, 10 (100%) were approved restraints. k. In nine of 10 of these records (90%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. All individuals had a positive behavior support plan in place to address identified behaviors. The restraint monitor indicated that Individual #247 was exhibiting SIB due to pain on 1/23/14. There was no evidence that he was referred to the physician to determine the source of pain prior to receiving a chemical restraint. l. The facility reported that there were 11 individuals subjected to restraints classified as protective mechanical restraints (PMRs). Four were reviewed by the monitoring team (Sample C.7). Four (100%) followed state policy regarding the use, management, and review of PMR. The facility reported that all 11 individuals had a protective mechanical restraint plan in place to address application and monitoring of the restraint. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility needs to ensure that all restraints are documented and monitored as required. 2. Staff need to clearly document what lead to the behavior requiring the use of restraint.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	b. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 22 of the 24 (92%) had current training in RES0105 Restraint Prevention and Rules. • 18 of the 21 (86%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training • 22 of the 24 (93%) had completed PMAB training within the past 12 months. • 18 of the 21 (86%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. d. In nine of the records (90%), 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 (see C.1.h)	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	a. Based on a review of 10 restraint records (Sample #C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. Eight of eight individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for eight individuals in the sample, there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint) (100%). 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 SIB. d. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders or the facility's Do Not Restrain List. e. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and/or the form used by the facility to document restraint considerations/restrictions. f. In 10 of 10 restraint records reviewed in Sample #C.1 (100%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis	Noncompliance

#	Provision	Assessment of Status	Compliance
		intervention plan. In reviewing documentation from Sample #C.3 for individuals for whom restraint had been used for the completion of medical or dental work: • g. Zero of five (0%) showed that there had been appropriate authorization (i.e., Human Rights Committee) approval and adequate consent. Documentation was not submitted. • h. Zero (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. The facility reported that there were no medical or dental desensitization plans in place. Four of the ISPs reviewed included SAPs to address toothbrushing. Without adequate documentation of discussion regarding the use of pretreatment sedation, it was not possible to determine if strategies were adequate. o Individual #32's ISP indicated that he did not need pretreatment sedation for routine exams. He received sedation on 2/25/14 prior to his dental exam and cleaning. Based on this review, the facility was not in substantial compliance with C4. To gain substantial compliance, the facility needs ensure that the IDT has discussed the use of restraint and strategies that might reduce the need for future restraint and ensured that the least restrictive intervention was used. The prevalent use of general anesthesia to complete routine dental exams should be further reviewed.	
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	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. Ten staff had been assigned the duty of restraint monitors. According to documentation provided to the monitoring team, six (60%) had been deemed competent to monitor restraints. This included the behavioral health specialists, campus supervisors, residential supervisors, and campus administrators. c. Based on review of document request II.19, staff who performed the duties of a restraint monitor in eight of 10 (80%) restraints in the sample had successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Exceptions were the restraints for Individual #16 on 10/24/13 and Individual #95 dated 11/6/13. Based on a review of 10 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In eight out of 10 incidents of restraint (80%) by an adequately trained staff	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	member. • e. In seven out of 10 instances (70%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint monitor did not arrive until 45 minutes after the restraint began for Individual #3 on 11/18/13. o The restraint monitor did not arrive until three hours after the initiation of a restraint for Individual #225 on 9/6/13. She did not complete the staff and individual interview section of the face-to-face assessment form. o A face-to-face assessment form was not included in restraint documentation for Individual #95 on 11/6/13. • f. In nine instances (90%), the documentation showed that an assessment was completed of the application of the restraint. The exception was for Individual #95. • g. In eight instances (80%), the documentation showed that an assessment was completed of the consequences of the restraint. The exceptions were for Individual #95 and Individual #225. A sample of ___ records for which physicians had ordered alternative monitoring schedules was reviewed. (none submitted) • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 10 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in six (60%) of the instance of restraint. The exception was: o Restraint checklists for Individual #304 dated 12/23/13 and Individual #3 on 11/18/13 indicated that one attempt was made by the nurse to obtain vital signs. Both individuals refused and a second attempt was not made. o The nursing assessment was completed late for Individual #304 following a restraint on 11/22/13. o Monitoring was not completed for the required frequency for Individual #247 on 1/23/14, • k. Monitored and documented vital signs in eight (80%). The exceptions were: o Individual #304 on 12/23/13 and Individual #3 on 11/18/13. • l. Monitored and documented mental status in eight (80%). The exceptions were:	

#	Provision	Assessment of Status	Compliance
		○ Individual #304 on 12/23/13 and Individual #3 on 11/18/13. Based on documentation provided by the facility, no restraint incidents had occurred off the grounds of the facility in the last six months. . • m. Conducted monitoring within 30 minutes of the individual's return to the facility in n/a of n/a (%). • n. Monitored and documented vital signs in n/a (%). • o. Monitored and documented mental status in n/a (%). Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months, • p. In five out of five (100%), the physician specified the schedule of monitoring required or specified facility policy was followed; and • q. In ___ out of ___ (n/a), the physician specified the type of monitoring required if it was different than the facility policy. r. In four out of five of the medical restraints (80%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. Exception was: • Individual #240 on 2/14/14 – no initial monitoring, monitoring by the nurse was not continued with the frequency ordered by the physician. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with C5, the facility will need ensure that: 1. A licensed healthcare professional monitors and documents vital signs and mental status of an individual with the frequency ordered by the physician. 2. Staff trained in the application and assessment of restraint 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.	
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 10 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In 10 (100%), continuous one-to-one supervision was provided; • b. In 10 (100%), the date and time restraint was begun; • c. In 10 (100%), the location of the restraint; • d. In eight (80%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. See C.1.g.	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	• e. In nine (90%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. See C.1.h.
		• f. In 10 (100%), the specific reasons for the use of the restraint;
		• g. In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint;
		• h. In 10 (100%), the names of staff involved in the restraint episode;
		• Observations of the individual and actions taken by staff while the individual was in restraint, including:
		  ○ i. In 10 (100%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration).
		  ○ j. In ___ (n/a) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint. The longest physical restraint in the sample was 15 minutes.
		  ○ k. In ____ (n/a), 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 10 (100%), the level of supervision provided during the restraint episode;
		• m. In eight physical restraints (100%), the date and time the individual was released from restraint; and
		• 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.
		
		o. In a sample of 10 records (Sample #C.1), restraint debriefing forms had been completed for 9 (90%). The exception was for Individual #95.
		
		p. A sample of five individuals subject to pretreatment sedation for dental treatment was reviewed (Sample #C.3), and in four of five (80%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. The facility reported that documentation was not available for medical restraints. Exception was Individual #240
		
		q. In two (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the behavior specialist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met.
		
		Data regarding the extent of the use of chemical restraint at the facility may be misleading. Since the previous review, the facility had begun to categorize the	

#	Provision	Assessment of Status	Compliance
		administration of additional psychotropic medication as "Psychotropic Emergency Medication Administration" (PEMA). There was no policy and procedure outlining this designation, and the use of these medications did not result in post restraint monitoring or review. Further, as noted in C1, the state's recently revised restraint policy changed the definition of chemical restraint to one that was no longer in line with the definition that is in the Settlement Agreement. From September 2013 through April 2014 there were 16 administrations of PEMA for eight individuals. See section J3 for further comments regarding this practice.	
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 SASSLC documentation, during the six-month period prior to the onsite review, two individuals were placed in restraint more than three times in a rolling 30-day period. This was an increase from the last review when one individual was placed in restraint more than three times in a rolling 30-day period. These individuals (i.e., Individual #304 and Individual #39) were reviewed by the monitoring team to determine if the requirements of the Settlement Agreement were met. Their PBSP, crisis intervention plan, and individual support plan addendum (ISPA) that occurred as a result of more than three restraints in a rolling 30-day period were reviewed. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. In past reviews, the facility achieved substantial compliance for provisions C7a, b, c, d, and g because the IDT and behavioral health services staff reviewed, as required, those aspects described in each of these five provision items. In each of the past reviews, the review did not require any changes in treatment and, thus, the facility met substantial compliance. For this compliance review, however, changes in treatment were necessary. This appeared to have been done by the facility, but it was not documented clearly and as required by provision C7. The monitoring team discovered that behavioral health services leadership was not aware of the documentation requirement, due to turnover in the department's leadership position. Based upon detailed discussion with the behavioral health services director and based upon review of documentation, the monitoring team has kept this provision in substantial compliance with the expectation that proper documentation will be in place for the next compliance review. The IDT reviewed and discussed the potential role of adaptive skills, and biological,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		medical, and psychosocial issues. In order to maintain substantial compliance with this provision item, the minutes from at least 85% of the individuals' ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. Additionally, in future reviews, SASSLC will need to ensure that this information is contained in a section of the ISPA that directly corresponds with this item.	
	(b) review possibly contributing environmental conditions;	The IDT reviewed possibly contributing environmental conditions. Please see second paragraph above in C7a. In order to maintain substantial compliance with this provision item, the minutes from 85% of the individual's ISPA meetings following more than three restraints in a rolling 30-day period should review possibly contributing environmental conditions (e.g., noisy environments, presence of novel staff, etc.), and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. Additionally, in future reviews, SASSLC will need to ensure that this information is contained in a section of the ISPA that directly corresponds with this item.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	The IDT reviewed structural assessments/environmental antecedents. Please see second paragraph above in C7a. In order to maintain substantial compliance with this provision item, the minutes from at least 85% of the individuals' ISPA meetings following more than three restraints in a rolling 30-day period should review potential environmental antecedents (e.g., placing demands, focusing attention on other individuals, etc.) and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. Additionally, in future reviews, SASSLC will need to ensure that this information is contained in a section of the ISPA that directly corresponds with this item.	Substantial Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	The IDT reviewed functional assessments and discussed the variables hypothesized to be maintaining the dangerous behavior. Please see second paragraph above in C7a. In order to maintain compliance with this provision item, the minutes from at least 85% of the individual's ISPA meetings reviewed following more than three restraints in a rolling 30-day period should reflect a discussion of the variables maintaining the dangerous behavior that provokes restraint. Additionally, if a variable or variables are identified hypothesized to be maintaining the target behavior that provokes restraint, ISPA minutes should also reflect an action to address this potential source of motivation for the target behavior. Finally, in future reviews, SASSLC will need to ensure that this	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		information is contained in a section of the ISPA that directly corresponds with this item.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	This item continued to be in substantial compliance. Both Individual #304 and Individual #39 had PBSPs to address the behaviors provoking restraint. The following was found: • Both of the PBSPs reviewed (100%) specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • Both of the PBSPs reviewed (100%) specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • Both of the PBSPs reviewed (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • Both of the PBSPs reviewed contained interventions to weaken or reduce the behaviors that provoked restraint that were based on functional assessment results Both Individual #304 and Individual #39 had a crisis intervention plan. The following was found: • For both of the crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • For both of the crisis intervention plans reviewed (100%), the maximum duration of restraint authorized was specified, • For both of the crisis intervention plans reviewed (100%), the designated approved restraint situation was specified, and • For both of the crisis intervention plans reviewed (100%), the criteria for terminating the use of the restraint were specified.	Substantial Compliance
	(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	This item continued to be in substantial compliance. At the time of the onsite review, data were available demonstrating that for both Individual #304 and Individual #39 (100%), their PBSP was implemented with integrity at a level above 85%. In order to maintain substantial compliance with this provision item, SGSSLC needs to ensure that at least 85% of individuals with more than three restraints in a rolling 30-day period have treatment integrity data that indicates that at least 85% the PBSPs were implemented as written.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(g) as necessary, assess and revise the PBSP.	The IDT assessed and revised PBSPs. Please see second paragraph above in C7a. In order to maintain substantial compliance with this provision item, 85% of the individuals who were placed in restraint more than three times in a rolling 30-day period should have evidence (in the ISPA) of a review, and revision when necessary, of the current PBSP. Additionally, in future reviews, SASSLC will need to ensure that this information is contained in a section of the ISPA that directly corresponds with this item.	Substantial Compliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The facility had a restraint review system in place for all crisis intervention restraints. All restraints continued to be reviewed by the behavior specialist, unit directors, and IMRT. A sample of documentation related to 10 incidents of crisis intervention restraint was reviewed (Sample #C.1), this documentation showed that: • a. In nine (90%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exception was: o Individual #304 on 12/23/13 • b. In nine (90%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. The exception was: o Individual #304 on 12/23/13 • c. In 10 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 10 (100%), the review conducted by the restraint monitor and/or behavior specialist was sufficient 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. • e. The restraint monitor, behavior specialist, and/or the unit director did not document recommendation from their review for the restraints in sample #C.1. Follow-up to recommendations was documented for n/a (%) recommendations. • f. None were referred to the team for review of the individual's ISP or PBSP. • Of the five referred to the team, in four (80%), appropriate changes were made to the individuals' ISPs and/or PBSPs. • A review of restraint documentation in the sample indicated that there were no further recommendations made for IDTs were following up on (i.e., retrain staff, referral to the psychiatrist or PCP)	Substantial Compliance

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Section D Presentation Book o SASSLC Section D Self-Assessment o DADS Policy: Incident Management #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 o SASSLC Policy: Incident Management effective 11/5/13 o SASSLC Policy: Protection from Harm – Abuse, Neglect, and Exploitation effective 11/5/13 o Incident Management Review Committee meeting minutes for each Monday of the past six months o Unit Meeting Minutes for the past six months o QA/QI report for the past two quarters o Abuse/Neglect/Exploitation Trend Reports for the past two quarters o Injury Trend Reports for the past two quarters o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious incidents and injuries since 9/1/13 o All injury report for the past six months for any individual sustaining a serious injury o List of all ANE allegations since 9/1/13 including case disposition o A list of all investigations completed by the facility in the last six months. o List of employees reassigned due to ANE allegations o Training transcripts for all facility investigators o SASSLC/DFPS/OIG Quarterly meeting minutes o Documentation from the following completed investigations, including follow-up:

Sample D.1.a	**Allegation**	**Disposition**	**Date/Time of APS Notification**	**Initial Contact**	**Date Completed**
#43027721	Neglect	Unconfirmed	2/13/14 5:37 pm	2/14/14 4:07 pm	2/21/14
#43018646	Neglect (3)	Confirmed (2) Unconfirmed (1)	2/6/14 8:36 am	2/6/14 4:39 pm	3/3/14
#42985155	Physical Abuse	Inconclusive	1/8/14 7:22 am	1/8/14 6:16 pm	1/24/14
#42985221	Neglect (2) Physical Abuse (1)	Unconfirmed (2) Other	1/7/14 6:09 pm	1/10/14 5:45 pm	2/12/14
#42941165	Neglect	Unconfirmed	11/20/13 8:44 am	11/21/13 2:47 pm	11/27/13

#42938656	Neglect (4)	Unconfirmed (3) Confirmed (1)	11/18/13 12:30 pm	11/20/13 6:15 pm	12/12/13
#42934489	Neglect (2) Physical Abuse (2)	Unconfirmed (2) Unconfirmed (1) Confirmed (1)	11/13/13 6:48 pm	11/15/13 5:37 pm	12/9/13
#42936569	Physical Abuse	Unconfirmed	11/15/13 1:22 pm	11/15/13 6:56 pm	11/25/13
#42930813	Neglect (2)	Unconfirmed (2)	11/11/13 11:19 am	11/12/13 2:05 pm	11/21/13
#42872473	Physical Abuse (2)	Unconfirmed (2)	9/19/13 1:25 am	9/20/13 2:49 pm	9/27/13
Sample D.1.b	**Allegation**	**Disposition**	**Date/Time Incident Reported**	**Date Completed**	
#43018629	Neglect	Referred Back	2/6/14 8:17 am	2/13/14	
#43005440	Neglect	Referred Back	1/26/14 9:46 am	2/10/14	
#42990964	Neglect	Referred Back	1/13/14 3:28 pm	1/23/14	
#42888908	Neglect	Clinical Referral	10/3/13 1:08 pm	10/9/13	
#42858951	Verbal Abuse	Referred Back	9/6/13 4:37 pm	9/9/13	
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
#14-045	Serious Injury	3/10/14 4:10 am	3/10/14 4:14 am	3/14/14	
#14-043	Serious Injury	3/4/14 8:15 pm	3/4/14 8:25 pm	3/5/14	
#14-038	Serious Injury	2/7/14 11:40 am	2/7/14 11:40 am	2/18/14	
#14-026	Serious Injury	12/30/13 7:30 pm	12/30/13 8:20 pm	1/5/14	
#14-022	Serious Injury	12/2/13 12:25 pm	12/2/13 12:30 pm	12/3/13	

	Interviews and Meetings Held: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Charlotte Fisher, Director of Behavioral Services o Adrianne Berry, Incident Management Coordinator o Rhonda Sloan, QIDP Coordinator o Joan O'Connor, Assistant Director of Programming Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 4/28/14 and 4/29/14 o Morning Unit Meeting 5/1/14 o Morning Clinical Meeting 4/28/14 o QA/QI Meeting 4/29/14 o ISP preparation meeting for Individual #255 and Individual #12 o Annual IDT Meeting for Individual #337 and Individual #90
	Facility Self-Assessment: SASSLC submitted its self-assessment. Along with the self-assessment, the facility had two other documents that addressed progress towards meeting the requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement. The second document listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. Completed investigations were reviewed for compliance with each provision item. Additionally, the facility looked at other documentation relevant to each provision. For example, for D2a, the facility also looked at staff training records to confirm that a sample of employees had signed the Acknowledgement of Responsibility for Reporting A/N/E. The facility's review of its own performance found compliance with 21 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 18 of 22 provisions. Four of eight provision items reviewed were found to be in substantial compliance. The monitoring team did not confirm compliance with the requirements of D2c, D3e, D3i, and D4. The facility should note findings by the monitoring team for each provision found not to be in substantial compliance and consider further review of those provisions using similar methods used by the monitoring team. The focus of the review should be on recommendations and follow-up to issues noted during the

	investigation process and positive outcomes in reducing the number of incidents and injuries at the facility.
	Summary of Monitor's Assessment: According to a list provided by SASSLC, DFPS conducted investigations of 119 allegations at the facility between 9/1/13 and 2/28/14, including 46 allegations of abuse, 72 allegations of neglect, and one allegation of exploitation. Of the 119 allegations, there were six confirmed cases of abuse and 11 confirmed cases of neglect. The facility reported that 38 other serious incidents were investigated by the facility during this period. There were a total of 1390 injuries reported between 9/1/13 and 2/28/14. These 1390 injuries included 26 serious injuries resulting in fractures or sutures. This indicated an overall increase in the number of injuries reported the previous six-month period, and the number of serious injuries reported. Injury trends were being generated per individual and were made available to IDTs for planning. The incident management department was preparing data reports for the monthly QA/QI unit meetings regarding injuries and injury trends. It was still not evident that IDTs were proactive in revising supports and monitoring implementation following incidents. The parties agreed that there would be no monitoring for 14 of the 22 section D provisions that were found to be in substantial compliance during the last three or more monitoring visits. During this review, the monitoring team found the facility to be in substantial compliance with four out of eight provisions of section D that were reviewed. Provision items found not to be in compliance were: • D2c: The facility was still not ensuring that staff completed training on identifying and reporting abuse and neglect on an annual basis. • D3e: 50% of the DFPS investigations were not completed within 10 calendar days of the incident being reported. There was not sufficient evidence that the delay was because of extraordinary circumstances in the investigations not completed in a timely manner. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends of injuries and incidents.

#	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	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	are required to report abuse or neglect of individuals.		
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		

	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The state policy required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement.
		
		According to a list of all abuse, neglect, and exploitation investigations, there investigations involving 119 allegations of abuse, neglect, or exploitation conducted by DFPS at the facility between 9/1/13 and 2/28/14. From these 119 allegations, there were:
		• 46 allegations of abuse including,
		  ○ 6 confirmed
		  ○ 24 unconfirmed
		  ○ 12 inconclusive
		  ○ 1 unfounded
		  ○ 3 referred back for further investigation
		• 72 allegations of neglect including,
		  ○ 11 confirmed
		  ○ 37 unconfirmed
		  ○ 9 inconclusive
		  ○ 13 referred back to the facility for further investigation
		  ○ 3 unknown
		• 1 allegation of exploitation referred back to the facility for further investigation
		
		According to a list provided by the facility, there were 38 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included:
		• 18 serious injuries/determined cause,
		• 1 serious injuries from peer-to-peer aggression,
		• 13 serious injury/undetermined cause
			Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 2 sexual incidents, • 0 choking incident, • 0 suicide threats, • 1 encounter with law enforcement, • 11 unauthorized departures, and • 6 deaths. From all investigations since 10/1/13 reported by the facility, 20 investigations were selected for review. The 20 comprised two samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample (15 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (5 cases). 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 SASSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Based on responses to questions about reporting, n/a of n/a (%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. All staff were required to wear a badge with reporting requirements listed on the back of the badge. Metric 2.a.5: Based on responses to questions about reporting, n/a of n/a (%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents.	

#	Provision	Assessment of Status	Compliance
		Based on a review of the 10 investigation reports included in Sample #D.1a: • Metric 2.a.6: 10 (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. • Metric 2.a.7: Nine (90%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o Nine of 10 (90%) indicated the facility director or designee was notified of the incident within one hour. The exception was DFPS case #42985221. o Eight of eight (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o Nine of 10 (90%) documented that the state office was notified as required. The exception was DFPS case #42985221. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (n/a) included recommendations for corrective actions. Based on a review of five investigation reports included in Sample #D.2: • Metric 2.a.9: Four (80%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. o UIR 14-043 did not indicate the time of director notification. • Metric 2.a.10: Four (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For unusual/serious incident for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, the UIRs/investigation folders (n/a) included recommendations for corrective actions. Metric 2.a.12: The facility had a standardized reporting format. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. Metric 2.a.13: Based on a review of 20 investigation reports included in Samples #D.1 and #D.2, 20 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. The facility was in substantial compliance with the requirements of D2a.	

#	Provision	Assessment of Status	Compliance
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. The IMC reported that she was working with CTD to monitor training monthly. A list of employees with overdue training was being submitted to the facility director and assistant director of programming for disciplinary action. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. One employee was hired within the past year. • 21 (88%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • There was evidence that 17 of the 20 (85%) employees with current training who had been employed over one year had completed the ABU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 23 (96%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • There was evidence that 15 of the 20 (75%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on this review, the facility was not in substantial compliance with the requirement for annual training.	
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	report violations of such rights.		
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.		
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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 parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	<u>DFPS Investigations</u> The following summarizes the results of the review of 10 DFPS investigations (The five investigations referred back to the facility for further review were not used in this sample): • Investigations included in sample #D.1 noted the date and time of initial contact with the alleged victim. Documentation showed that some type of investigative activity took place within the first 24 hours in all cases. This included gathering evidence and making initial contact with the facility. o Contact with the alleged victim occurred within 24 hours in only three of 10 (30%) investigations. Though this is not a requirement for substantial compliance, additional efforts should be made to interview the alleged victim as soon as possible in order to preserve testimonial evidence. • For investigations in sample #D.1, five of 10 (50%) were completed within 10 calendar days of the incident. Although extensions were filed for all five investigations, it was not evident that extraordinary circumstances necessitated the extensions in all cases.	Noncompliance

#	Provision	Assessment of Status	Compliance
		○ Case #42985221 was completed on the 36th day. ○ Case #43018646 was completed on the 25th day. ○ Case #42985155 was completed on the 16th day. ○ Case #42938656 was completed on the 24th day. ○ Case #42934354 was completed on the 26th day. • All 10 (100%) resulted in a written report that included a summary of the investigation findings. • In six of 10 (60%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Five additional cases in sample #D.1 resulted in a referral back to the facility for further investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in five of five cases (100%). • Four of five (80%) indicated that the investigator completed a report within 10 days of notification of the incident. The exception was UIR 14-038. • Five of five (100%) included appropriate recommendations for follow-up action to address the incident. The facility did not maintain substantial compliance with this provision due to the delays by DFPS in completing investigations. The lengthy turnaround rate was noted during the last review, though the monitoring team assigned a substantial compliance rating. This ongoing trend of lengthy investigations needs to be addressed by the facility. Only 50% of the investigations in the sample were completed within 10 days and 40% resulted in multiple extensions. The facility's self-assessment documented 47 of 112 (42%) DFPS investigations were not completed within 10 days. The monitoring team recommends that the facility collaborate with DFPS to determine if action by the facility could facilitate more timely interviews with witnesses and/or address other barriers to completing investigations within 10 days.	
	(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 were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u>	Substantial Compliance

#	Provision	Assessment of Status	Compliance

	serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The following summarizes the results of the review of DFPS investigations in #D.1:
		• Metric 3.f.3: In 15 out of 15 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 15 (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.5: In 15 (100%), the name(s) of all witnesses;
		o Metric 3.f.6: In 15 (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.7: In 15 (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.8: In 15 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o Metric 3.f.9: In 15 (100%), all documents reviewed during the investigation;
		o Metric 3.f.10: In 15 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o Metric 3.f.11: In 15 (100%), the investigator's findings; and
		o Metric 3.f.12: In 15 (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 five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		• The report utilized a standardized format that set forth explicitly and separately:
		o Metric 3.f.14: In five (100%), each unusual/serious incident or allegations of wrongdoing;
		o Metric 3.f.15: In five (100%), the name(s) of all witnesses;
		o Metric 3.f.16: In five (100%), the name(s) of all alleged victims and perpetrators;
		o Metric 3.f.17: In five (100%), the names of all persons interviewed during the investigation;
		o Metric 3.f.18: In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;	

#	Provision	Assessment of Status	Compliance
		○ Metric 3.f.19: In five (100%), all documents reviewed during the investigation; ○ Metric 3.f.20: In five (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; ○ Metric 3.f.21: In five (100%), the investigator's findings; and ○ Metric 3.f.22: In five (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this provision.	
	(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 2.g.1: The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that 1) the investigation is complete and 2) the report is accurate, complete, and coherent. Metric 2.g.2: The facility policy required 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 2.g.3: The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements). • Metric 2.g.4: The facility Incident Management Review Team (IMRT) did not note any problems with any of the investigations in the sample. • Metric 2.g.5: The monitoring team did not identify problems with regard to sections D.3.e and/or D.3.f. Based on a review of the facility's IMRT data, for n/a (__%), the facility IMRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. • Metric 2.g.6: The facility returned no cases in the sample to DFPS for reconsideration for __ (n/a) (there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry). The IMC reported that cases were returned to DFPS when the facility did not agree with findings or had further concerns. The monitoring teams make no judgment regarding the adequacy of the DFPS supervisory process, and it has not been taken into consideration in assessing compliance for this subsection. UIRs included a review/approval section to be signed by the Incident Management	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1, • 15 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 12 (80%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. o The UIR for case #42938656 was not signed by the IMC or facility director. The investigation review form was signed by both 11 days after the close of the investigation. o The IMC and director signed the UIR for DFPS case #42872473, however, there was no date of review. o Review by the IMC and director of DFPS case #428858951 occurred on 9/18/13. DFPS completed the case on 9/9/13 <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In four out of five investigation files reviewed (80%), 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. o Documentation of activities completed during the investigation of UIR14-043 did not include the correct date and/or time. The investigator documented that interviews with witnesses occurred prior to the incident. The IMC signed the report without noting the discrepancies. The facility was in substantial compliance with investigation review requirements.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 20 out of 20 (100%) unusual incidents reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. Metric 3.h.1: The facility-only investigations met the requirements outlined in Section D.3.f.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall	Metric 3.i.1: The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric 3.i.2: The facility discussed follow-up to recommendations in the daily IMRT	Noncompliance

#	Provision	Assessment of Status	Compliance
	implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	meeting minutes. There was no evidence that a review was completed of follow-up (to ensure protections were effective and/or continued to be implemented). A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of six cases: • Four DFPS cases: #42938656, #42934489, #43018646, #43005440, #42990964 • One facility investigations: UIR 14-026 Metric 3.i.3: For three out of three (100%) of the DFPS investigations (DFPS cases #42934489, #43018646, #43005440) reviewed in which disciplinary action was warranted, prompt and adequate disciplinary action had been taken and documented. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric 3.i.4: For three out of six of the investigations reviewed (50%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. DFPS case #42934489, 43005440, and #42990964 documented that recommendations were addressed by the facility. The exceptions were: • The investigation file for DFPS case #42938656 did not include documentation of follow-up to recommendations made in the case. Neglect was confirmed on an unknown AP when the investigator found that residential staff had not been trained on the AV's PNMP. Several recommendations were made including developing a system for training staff on PNMPs and ensuring that staff named in the case were trained. The IMC did not follow-up to confirm that recommended follow-up was completed. • DFPS case #43018646 included a recommendation to train all residential staff at the home involved on use of bathing equipment. Documentation indicated that training was not completed until three weeks after the incident. All staff should have been trained immediately to prevent similar incidents from occurring. • UIR 14-026 was the investigation of a fall resulting in a serious injury on 12/30/13. The AV had a trend of falls resulting in serious injury. The doctor recommended a neurology consultation. The UIR indicated that this action was completed on 12/17/13. The consultation was not requested until 12/20/13 and was completed on 12/25/13 with additional recommendations to obtain a neurosurgical consultation and follow-up with the neurologist in four weeks. The investigation file did not include documentation showing that the incident management department was tracking confirmation of completion for this follow-up recommendation. IMRT minutes did not show tracking by the IMRT. Metric 3.i.5: For zero out of six investigations (0%), there was documentation to show	

#	Provision	Assessment of Status	Compliance
		that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility did not have a system to track outcomes from investigations. Based on identified issues with the implementation of recommendations and desired outcomes, the facility remained out of compliance with this provision.	
	(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.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	Metric 4.1: For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending by: • Type of incident; • Staff alleged to have caused the incident; • Individuals directly involved; • Location of incident; • Date and time of incident; • Cause(s) of incident; and • Outcome of investigation. Over the past two quarters, the facility's trend analyses: • Metric 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did contain recommendations for corrective actions, however, recommendations were broad and did not include measurable outcomes. For example, recommendations to address the high incidence of falls at the facility included: o IMC will provide trend reports to the IDTs o IM department will continue to send email notification reminders when an individual has sustained more than two falls for the IDT to monitor	Noncompliance

#	Provision	Assessment of Status	Compliance
		and meet if required. o Each month medical department and IM will trend all falls to track injurious falls. o Trends identified are shared with the UD and IDTs to address within unit meetings. Follow-up is reported in facility monthly IMC report. The IMC reported that she reviewed data monthly and quarterly and made recommendations to address trends based on data analysis. Additionally, • Quarterly reports were submitted to the Quality Assurance Department. • Data were provide to ISP facilitators for review at annual IDT meetings prior to the meeting. Metric 4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans (CAPs) that included measurable outcomes were not typically developed. When there were recommendations for corrective action, it was difficult to determine what specific action had been implemented, how it was being monitored, and what data were used to determine the efficacy of the plan. Metric 4.8: Even when appropriate to do so, corrective action plans were not always developed both for specific individuals and at a systemic level. None of the investigations in the sample reviewed demonstrated that when a trend of similar incidents or injuries was identified, an adequate corrective action plan was developed and outcomes were tracked. Metric 4.9: The trend reports and minutes did not show that corrective action plans were implemented and tracked to completion. Metric 4.10: The trend reports/minutes did not review, as appropriate, the effectiveness of previous corrective actions. There were no comments regarding previously developed corrective action plans. Based on a review of quarterly trend reports and IMRT minutes: • Monthly and quarterly trend reports did not include action plans with specific outcomes related to trends identified. • Action steps were not included to address both systemic and individual trends. IMRT meeting minutes showed that occasionally action steps were developed to address trends, however, action steps were generic referrals to the IDT. From that point, it was difficult to assess the status of action steps. Metric 4.11: Zero action plans included in the monthly trend report (there were none)	

#	Provision	Assessment of Status	Compliance
		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 4.12: For zero of the action plans reviewed (there were no action plans developed), the plan had been timely and thoroughly implemented. Metric 4.13: For zero action plans (there were no action plans developed), 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. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed, 2. Specific staff are assigned to monitor and document implementation, and 3. A date is set to review efficacy of the plan and make revisions when needed.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, dated 1/26/12, updated 5/22/13 with new DADS administrative staff names o SASSLC facility-specific policies: • Quality Assurance, #E1, 9/19/13 (the quality assurance plan narrative) • CAPs process, #E2, draft (new) • Six other policies in the list of facility policies, all the same as last review: Facility Quality Assurance #200-1A, QAQI Council #400-5, Subgroup team meeting #400-4A, Subgroup calendar #400-4B, QAQI meeting agenda format #400-5A, and QAQI calendar #400-5C o SASSLC organizational chart, undated but likely February 2014 o SASSLC policy lists, undated, 2/15/14 o List of typical meetings that occurred at SASSLC, undated but likely February 2014 o SASSLC Self-Assessment, 4/17/14 o SASSLC Action Plans, 4/17/14 o SASSLC Provision Action Information, 3/23/14 o SASSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/28/14 o SASSLC DADS regulatory review reports, 10/18/13-1/21/14 o SASSLC data listing/inventory, hard copy, March 2014 o SASSLC QA plan narrative, 3/26/14 o SASSLC QA plan matrix, 3/26/14 o List tools used by the QA department staff (3, no changes) o Standard trend analysis reports for four areas, for quarter ending November 2013 for three of the areas and February 2014 for one of the areas o Monthly QAD-SAC-1: 1 meetings minutes, November 2013 to March 2014 o SASSLC QA Reports, monthly, October 2013 to March 2014 (6) o QAQI Council presentation calendar, 1/21/14 o QAQI Council minutes, at least monthly (almost weekly at SASSLC), 11/7/13 to 4/29/14 (6 months, 22 meetings) • Handouts and agenda for meeting during onsite review, 4/29/14 o QA staff meeting handout about root cause analysis o Handouts from medical continuous quality improvement meeting o Handouts from unit 1 QAQI meeting o PIT, PET, work group reports (no separate documentation) o SASSLC Corrective Action Plan documents • Draft CAPs process document, E.2 • Open CAPs report and monitoring sheet, updated weekly, 11/4/13 to 4/25/14

	▪ Various emails from Bill McCarthy to facility staff about CAPs • Closed CAPs report, 18 pages, 4/25/14 • Data regarding CAPs (in QA reports) <u>Interviews and Meetings Held</u>: o Laurence Algueseva, Quality Assurance Director o Andy Rodriguez, SAC, and Kevin Elder, Bill McCarthy, staff of the QA department o Dr. Espino and other medical staff, mortality review process, 5/1/14 <u>Observations Conducted</u>: o 1:1 QAD SAC meeting, with unit director unit 2, 5/1/14 o QA staff meeting, 5/1/14 o QAQI Council, 4/29/14 o Unit QAQI meeting, Unit 1, 4/30/14 o Medical CQI, 4/30/14
	Facility Self-Assessment The QAD made some changes and additions to the activities in his self-assessment. It contained more activities and these activities lined up more with the monitoring team's report. Given that this report has alpha-numerically labeled the metrics, this should provide further guidance to the QA director for his next self-assessment. That is, the QA director could use these metrics in his own self-assessment. If so, however, he should be sure to read all of the detail provided within the report for each metric because there is important supplemental information provided. The facility self-rated itself as being in substantial compliance with E3 and in noncompliance with sections E1, E2, E4, and E5. The monitoring team agreed.
	Summary of Monitor's Assessment: The QA program at SASSLC continued to make progress. In particular, the "infrastructure" of the QA program was established: the data list inventory and a process for regular review, the QA narrative, QA matrix, 1:1 meetings, QA Council presentations, QA report, and CAPs program. There were eight deaths in the past six months. This serious outcome was not picked up by any of the items in the inventory, QA matrix, or QA reports indicating problems in the collection and monitoring of data at the facility. In the last report, the monitoring team noted frequent references to root cause analyses, intense case analyses, and continuous quality improvement. The QA director pursued additional training and Dr. Sharon Tramonte (SASSLC pharmacy director) created an introductory 30-minute training session on root cause analysis.

	Of the 16 data list inventories, 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 2 (13%) included a wide range of data that appeared to cover all aspects of the discipline and Settlement Agreement (N and U); 14 (88%) included what appeared to be key indicators; 16 (100%) described the data being collected; and 7 (44%) included a self-monitoring tool. None of the items were notated to be a process or an outcome indicator. The QAD and SAC should consider devoting one full 1:1 meeting to the inventory and skip the other topics for that month. The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council. In addition, the matrix (and thereby the inventory too) should include (a) items that get at the requirements of the wording of section E1 regarding the collection of data per program areas, living units, individuals, etc., and (2) both process and outcome measures. Since the last onsite review, a QAD-SAC 1:1 meeting occurred at least twice for 20 of the 20 (100%) sampled sections of the Settlement Agreement. The QAD and SAC reported that they hadn't yet, but were planning to, include data reviews during these meetings. In the last six months, a facility QA report was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 15 (75%) appeared in a QA report at least once each quarter. There should be an analysis of the causes of the problem, not just a description of their occurrence. The sections that came closest to doing so were D and M. Since the last onsite review, the QAQI Council did meet at least once each month. The QAQI Council at SASSLC met almost every week, allowing for the meetings to be relatively short and to be a regular part of each manager's weekly schedule. Continued work was done to improve the CAPs system. The facility set the expectation that CAPs would be completed within the allotted time frame (extensions were no longer easily granted), and one of the program auditors had the responsibility of personally talking with each person responsible for an open CAP every week. He documented this with a signature from the responsible person. Also, at the end of each week, he updated the open CAPs log. There was, however, no criterion to judge when/if the overall CAP was being met. Most were not written in a behavioral objective type format with the observable behavior and observable criteria clearly described. Many of the CAPs were initiated months, if not more than a year ago, making it impossible for the monitoring team to make a determination that they were implemented timely and fully. The QAD director was just initiating a very creative and important activity to reviewing 40% of all closed CAPs to see if the corrections were maintained and the issues for which the CAP was created remained at a satisfactory level.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The QA program at SASSLC continued to make progress, in some ways, more so than ever before. In particular, the "infrastructure" of the QA program was established: the data list inventory and a process for regular review, the QA narrative, QA matrix, 1:1 meetings, QA Council presentations, QA report, and CAPs program. The QA director, Larry Algueseva, continued to take seriously the monitoring team's comments in previous reports and onsite reviews. He worked closely with the Settlement Agreement Coordinator, Andy Rodriguez. All of the members of the QA department remained the same, which helped to support consistency and progress. A QA staff meeting was held from time to time. <u>Policies</u> a. There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, #003.1: Quality Assurance, updated 5/22/13. The monitoring team's comments on the state policy are in previous monitoring reports and are not repeated here. b. There were facility policies that adequately supported the state policy for quality assurance. The QA plan narrative remained as one of the facility specific policies. The QA director should correct the list of QA policies that were included in the facility-wide set of policies because that list was incorrect and outdated. A new policy/process was in draft form for CAPs. It is discussed below in section E2 of this report. <u>Quality Assurance Data List/Inventory</u> c. There was not yet a complete and adequate data list inventory at the facility. The data list inventory was 32 pages long, contained 22 topic areas (seven were not Settlement Agreement related). Sections C and K were combined in one topic area; and sections O, P, and R were combined in one topic. 18 of the 20 provisions of the Settlement Agreement (90%) were included (all except for G and H). Of the 16 inventories (O-P-R were combined, C-K were combined), 16 (100%) included data that could be used to identify trends as required in the wording of section E1; 2 (13%) included a wide range of data that appeared to cover all aspects of the discipline and Settlement Agreement (N and U); 14 (88%) included what appeared to be key indicators (not J and K); 16 (100%) described the data being collected; and 7 (44%) included a self-monitoring tool (section N did not appear to need a self-monitoring tool, but this was not stated; for some sections a self-monitoring tool was in the QA matrix but not in the inventory). None of the items were notated to be a process or an outcome indicator.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility needs to demonstrate that each data listing is complete, that is, that (a) it includes all relevant data items (and that no important data items are missing), (b) each data item is indeed being collected by the section leader, (c) each is available for presentation if requested, and (d) data are being used as per the wording of this Settlement Agreement provision. As discussed during the onsite review, this information might be included in the data listing inventory database or perhaps within the SAC-QAD 1:1 meeting minutes. d. The data list inventory was current. 12 of the 16 lists (75%) were updated within the past six months. Each inventory had its own date of update. Two had no date, but were likely reviewed recently, one had a date in March 2013, which may have been a date entry error, and one had a date of April 2013. The monitoring team has a number of comments and suggestions for the QA director to help make the data list inventory a more functional and useful tool for the facility: • It was good to see a brief description of each data item. This helps the reader (and QAQI Council) to understand what was being measured. • The key indicator list was rolled into the inventory. This was also good to see. o The key indicators (for the most part), however, were not what appeared in the QA matrix and in the QA report. • The content of the inventories needed work. The monitoring team suggests that the QAD and SAC devote one full 1:1 meeting to the inventory and skip the other topics for that month. The inventory plays an important foundational role for the entire QA program and, therefore, needs to be valid. o The QAD and SAC need to ensure that the inventory lines up with what is in the QA matrix and what is in the QA report. For most of the sections, it did not. That is, they were three different sets of information. Now that the QA program had the "infrastructure" the quality of the content needs to be given a thorough review. • There were eight deaths in the past six months. This serious outcome was not picked up by any of the items in the inventory (or in the QA matrix or QA reports). This should be addressed. o State office completes a month to month graph of number of deaths in each facility. Perhaps the medical department and QA program can access this, however, it seems to be a salient piece of information that the facility's departments could easily manage. • Nine of the 24 items in the QA department's inventory seemed to belong to other sections. • All of the items in the residential unit director inventory were related to one of	

#	Provision	Assessment of Status	Compliance
		the other topic areas. This should somehow be tied together. <u>Quality Assurance Plan Narrative</u> e. The QA plan narrative was current, complete, and adequate. <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; most (but not necessary all) of these data are then included in the QA reports and presented to the QAQI Council. • SASSLC had a QA plan matrix. It was updated somewhat from the last plan, however, it did not accurately reflect the key indicators from the data list inventory. This begged the question of whether the inventory contained the correct key indicators or whether the matrix contained the correct items. The items in the QA matrix should line up with the data list inventory, content of the QAD-SAC 1:1 meetings, content of the QA reports, and presentation at QAQI Council. • These aspects of the QA program at SASSLC did not line up. Evaluating this correspondence was not being done, but should be. Overall, the facility was not using the QA matrix as it was intended, that is, to be a subset of the data listing, such that it correctly showed which data were to be presented during QAD-SAC 1:1 meetings, in the QA report, and to QAQI Council along with more detail on how the data were to be collected, reviewed, and managed. Simply, the matrix should be items pulled from the inventory. SASSLC seemed to try to set this up by labeling some inventory items as key indicators. One would then expect to see the key indicators in the matrix. But that was not the case. The matrix did not contain all of the key indictors, it contained items that were not key indicators, and it contained items that were not in the inventory. In addition, many inventories did not include a self-monitoring tool, but a self-monitoring tool was in the matrix. In addition, the matrix (and thereby the inventory too) should include (a) items that get at the requirements of the wording of section E1 regarding the collection of data per program areas, living units, individuals, etc., and (2) both process and outcome measures. Because of the many problems with the QA matrix, the monitoring team did not (could not) review the status of the QA matrix. Therefore, the metrics f-s are merely listed below, with no data, but with some comments.	

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		f. There were items in the QA plan matrix for -- of the 20 sections (--%). The items represented a set of key indicators for -- of the 20 (--%). g. Of the 20, both process and outcome indicators were identified for -- of the 20 (--%) in the QA matrix. h. Of the 20, in -- (--%), the indicators provided data that <u>could be</u> 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." o The QA director should describe, for each section (perhaps in the QA matrix and/or in the 1:1 meeting minutes) how data <u>were being</u> collected and presented to identify trends across the variables described in the wording of E1. i. The QA matrix (did/did not) include all self-monitoring tools/self-monitoring procedures. • It should include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement, or indicate that a self-monitoring tool was not necessary along with a rationale. j. All data that QA staff members collected should be listed in the matrix. k. All of the items in the QA matrix should also appear in the QA data list inventory. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. For the next review, the QA director, based on his own self-monitoring, should indicate if the items in the QA matrix were: l. Submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., at least once each quarter). m. Reviewed or analyzed by the QA department and/or the department section leader. This was likely reported to the QA department by the section leader during the 1:1 meetings. The QA director and SAC could easily report on this. n. Conducted and implemented as per the schedule. o. Received QA department assistance in analysis of data, or if there was no assistance	

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		provided, there was documentation that it was not needed. This likely occurred during the 1:1 meetings. The QA director and SAC could easily report on this. <u>Self-Monitoring Tools</u> p. Content/validity: A description of how the content of the tools was determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. q. 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. r. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. s. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement.	
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.	Continued progress was seen at SASSLC regarding the gathering, organization, and analysis of data. In the last report, the monitoring team noted frequent references to root cause analyses, intense case analyses, and continuous quality improvement, and suggested that the QA department receive training in this area. Some training was provided by state office on root cause analyses, however, based upon interviews of facility QA department staff, the monitoring team could not discern any direct value to the overall QA program. The QA director pursued additional training and Dr. Sharon Tramonte (SASSLC pharmacy director) created an introductory 30-minute training session on root cause analysis. The monitoring team attended this presentation. Overall, it was a good overview, but as Dr. Tramonte stated, she was not herself an expert in this topic. The monitoring team suggests that additional training be provided for QA department and for other interested discipline heads. The QA department and facility, in general, were eager to learn more and to improve their professionalism and skill at quality assurance activities. Unit level QAQI meetings were held each month in each of the three units. During the unit 1 meeting attended by the monitoring team, staff made three very professional and informative presentations. The medical CQI group continued to meet each month (see section L3). The nursing department engaged in error analysis, such as implementing the Five Whys for a medication administration error on 11/4/13.	Noncompliance

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		In this section (E2,) the monitoring team's findings were based upon the data that were included in the QAD-SAC 1:1 meetings documentation, in QA reports, and in QAQI Council meeting minutes. That is, the determination of whether the data presented by each department were correct (i.e., lined up with what was in the QA matrix) was done in section E1 above and was found to be in need of much improvement. Based upon the QA reports: a. Data from the QA plan matrix for n/a of the n/a (--%) sections of the Settlement Agreement were summarized. There was not full correspondence between what data were in the QA inventory, the QA matrix, and QA reports. Therefore, this metric could not be completed by the monitoring team. • Based upon the QA reports, however, few sections analyzed data 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. Some sections had done some breakdown/description of data across these areas, but no analysis (e.g., C, D, E, O, P, R, S, U). See more detail in metrics f. to h. below. <u>Monthly QAD-SAC meeting with discipline departments</u> The QA director and SAC continued to develop and improve upon these meetings. They were occurring every month. In addition: • The monitoring observed a meeting. It was with David Ptomey, unit director for unit 2. The meeting was much improved from last time. It was much more of an interactive discussion rather than an interrogation-type question and answer session. • The QAD and SAC used a checklist of topics and items. They scored the presence/absence of each item. This was good to see. It would be beneficial to all participants if the QAD and SAC were to write out the exact expectation (i.e., definition and criterion) of each item. • Data were not yet being reviewed at these meetings (even though data were being presented at QAQI Council and in the QA reports). The QAD and SAC, however, noted that their next step was to review actual data during these meetings. • It would be helpful to have a short paragraph in each month's meeting minutes that described aspects of the discussion. The minutes don't need to be extensive and should not compete with the conducting of the meeting, but currently there was no information about the meeting other than the checklist. • In some months, only one topic was a focus (e.g., self-assessments in December, policies in March). This was a good idea (and is suggested by the monitoring team above regarding focusing upon getting the content of the data list inventories correct and getting inventories, matrix, QA report, and QAQI Council	

#	Provision	Assessment of Status	Compliance
		presentation content to line up). At a minimum, however, each of the five bulleted items in metric b. below should be explicitly addressed at least once each quarter. b. Since the last onsite review, a meeting occurred at least twice for 20 of the 20 (100%) sampled sections of the Settlement Agreement (there were 16 regularly occurring meetings required to address all 20 sections of the Settlement Agreement because some meetings included multiple sections, such as O-P-R; moreover, beginning in March 2013 each unit director had a 1:1 meeting, too); all five topics below were conducted during 0 of the 74 (0%) meetings that occurred (during the five-month period of November 2013 to March 2014). • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. The QAD and SAC 1:1 meeting agenda topic checklist included all five of these bulleted topics, but without any narrative, definition, or criterion, the monitoring team was unable to determine the content and quality of these discussions and, therefore, scored the second part of the above metric as 0%. c. Since the last onsite review, during 0 of the 74 (0%) meetings, data were available to facilitate department/discipline analysis of data. As noted above, the QAD and SAC reported that they hadn't yet, but were planning to, include data reviews during these meetings. d. Since the last onsite review, during 0 of the 74 (0%) meetings, data were reviewed and analyzed. For the purposes of this metric, the monitoring team rates this as acceptable if there was review and discussion of data. The quality of the "analysis" is not considered. The QAD SAC agenda topic checklist included an item "QA report/analysis completed." The monitoring team believes this was scored yes if the department head said that his or her QA report was completed. Instead, it should be scored yes if the QAD and SAC's assessment of the analysis meets criterion (once the criterion is determined). e. Since the last onsite review, during 0 of the 74 (0%) meetings, action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed. CAPs were on the QAD SAC agenda topic checklist. Often it was scored n/a. Again, without	

#	Provision	Assessment of Status	Compliance
		narrative, definition, or criterion, the monitoring team could not determine the content or quality of the CAP review. <u>QA Report</u> The SASSLC QA report was assembled at the end of the month, following the completion of that month's presentations at QAQI Council. The information in the QA report was what was presented at QAQI Council. f. In the last six months, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the last six months (100%). g. Of the 20 sections of the Settlement Agreement, 15 (75%) appeared in a QA report at least once each quarter in the last six months. • There were no presentations of sections G, H, N, J, and K. • Sometimes the QAQI Council minutes indicated a presentation (in the agenda and with attached PowerPoint slides), however, the information was not also in the QA report (e.g., sections K and N, and parts of Q). This clerical task needs to be done accurately. h. Of the 20 sections of the Settlement Agreement that were presented quarterly, 0 (0%) contained all of the components listed below. • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate - Six sections reported use of a self-monitoring tool (C, D, I, Q, U, V). The others did not. - A short rationale (two or three sentences) for the absence of a self-monitoring tool should be included in those sections of the report. • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate - The content of the QA report did not line up with what was in the data list inventories or QA matrix. - 13 of the 15 sections presented a variety of other key indicators and important data; this was good to see. - An area for improvement is to show data and trends across the variables listed in E1 (or indicate clearly a rationale for not doing so). - The section E report should eventually include data on QA activities	

#	Provision	Assessment of Status	Compliance
		(e.g., from the QAD-SAC 1:1 meetings). • Narrative analysis - There should be an analysis of the causes of the problem, not just a description of their occurrence. The sections that came closest to doing so were D and M. - The QA director and SAC might include a template for the section leader that prompts one paragraph for a summary of the data and a separate paragraph for the analysis of the data. <u>QAQI Council</u> This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of the monthly QAQI Council meetings from 11/7/13 to 4/29/14 (6 months, 22 meetings). i. There was an adequate description of the QAQI Council in the QA plan narrative. j. Since the last onsite review, the QAQI Council did meet at least once each month. The QAQI Council at SASSLC met almost every week, allowing for the meetings to be relatively short and to be a regular part of each manager's weekly schedule. k. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics. l. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. m. Minutes (and attachments/handouts) from all 22 of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (indicators, self-monitoring) were presented in 22 (100%), (b) the data presented were trended over time in 22 (100%) and (c) comments and interpretation/analysis of data were presented in 0 of the presentations (0%). It is possible that the minutes did not accurately reflect the discussion that occurred during the meeting. Further, the minutes continued to be used as a repository of information for performance improvement teams and other topics (e.g., assessments) making it difficult for the reader to determine what was new information versus hold-over information from previous minutes. n. Minutes from 4 of the 22 (18%) QAQI Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. Beginning in March 2014, CAPs were regularly reviewed as a stand-alone topic and in April 2014, graphic summaries of	

#	Provision	Assessment of Status	Compliance
		overall CAPs status were presented, too. <u>Corrective Actions</u> Continued work was done to improve the CAPs system, including the creation, management, and reporting of CAPs. Corrective action plans were tracked by the QA director in two documents. One was for current open CAPs in a 6-page document that contained 30 CAPs as of 4/25/14. The other was for completed closed CAPs in a 18 page document. This was continued since the last onsite review. The number of closed CAPs was 180 as of 4/25/14. The 30 open CAPs were across 8 of the 20 provisions, and ranged from 15 in sections O and P (combined) to one each for sections N, S, and U. The set of closed CAPs ranged across more of the sections, but were primarily habilitation therapies. This was likely a result of that department utilizing the CAPs system rather than there being more corrective action plans needed for habilitation therapies than for other departments. At SASSLC, the entire CAPs management documentation was via the spreadsheet. Thus, the wording of the issue/reason, actions, outcomes, responsible persons, and target dates must provide sufficient detail for the QA director and senior management to adequately manage the program. The monitoring team reviewed a number of CAP-related documents. The number and breadth evidenced the efforts put into the CAPs program. • A new/draft policy (E2) described the CAPs program and expectations for staff participation • QAQI Council presentation materials from recent presentations by the QA department. General data about CAPs were included. • Log of open CAPs • Closed CAPs log • Weekly open CAPs monitoring sheet for almost every week since the last review. • Tabular and graphic summaries of CAPs-related data The facility set the expectation that CAPs would be completed within the allotted time frame (extensions were no longer easily granted), and Bill McCarthy (one of the program auditors) had the responsibility of personally talking with each person responsible for an open CAP every week. He documented this with a signature from the responsible person. Also, at the end of each week, he updated the open CAPs log. The monitoring team reviewed 12 of the 30 open CAPs and 4 of the more recently closed CAPs for the purposes of the following metrics, through E5.	

#	Provision	Assessment of Status	Compliance
		o. An adequate written description did exist that indicated how CAPs were generated, though more detail should be written regarding the criteria for the development of a CAP. Including examples of actions that would be considered CAPs and examples of actions that would not be considered CAP would help the QA department and senior management in determining when it was appropriate to create a CAP. p. When considering sample of CAPs, 12 of 16 open and closed CAPs were chosen following the written description, policy, or procedure (75%). Four of the CAPs did not address systemic facility-wide issues. They addressed a specific individual, staff member, or home. q. Of the 16 CAPs reviewed by the monitoring team, 13 (81%) appeared to appropriately address the specific problem for which they were created. • There was, however, no criterion to judge when/if the overall CAP was being met. None (0%) had a criterion attached to the overall CAP. The monitoring team suggests that the QA director consider each CAP to be an objective and, therefore, each would contain an observable/measurable action (think of actions as you would an observable behavior in a SAP or PBSP), and an observable measurable outcome with a criterion. • 0 of the 16 (0%) CAPs looked at assessing outcomes to ensure that the problem originally identified was remedied or reduced. None reported on the status of the problem; there were no data reported at all. • The QA director and Mr. McCarthy should ensure that each CAP includes a plan to ultimately assess the problem originally identified. Based on these 16 CAPs: r. 15 (94%) included the actions to be taken to remedy and/or prevent the reoccurrence. Most contained one action. s. 2 (13%) included the anticipated outcome of each action step. • 0 of 16 (0%) included specific criteria to judge if the outcome of each action step was met. Most were not written in a behavioral objective type format with the observable behavior and observable criteria clearly described. t. 0 of the 12 open (newer) CAPs (0%) included the job title and name of the person(s) responsible. u. 10 of the 16 (63%) included the time frame in which each action step must occur (i.e., a due date). Many said "ongoing."	

#	Provision	Assessment of Status	Compliance
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the 12 open/new CAPs, which represented 40% of the total: a. 12 (100%) included documentation about how the CAP was disseminated • Mr. McCarthy obtained a signature from each responsible person within the week of CAP initiation. • He also sent an email each week to all responsible persons. b. 12 (100%) included documentation of when each CAP was disseminated, and • The monitoring team determined documentation based upon the date of signature. c. n.a. (--%) included documentation of to whom it was disseminated, including the names and titles of the specific persons responsible. • As noted in E2 metric t., Mr. McCarthy needs to include the name and the title of the responsible person. Because this was in process, the monitoring team did not rate this metric (c.) in determining substantial compliance, but will need to see it demonstrated at the next review.	Substantial Compliance
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.	a. Based on a sample of 4 completed CAPs and 12 in-process (open) CAPs, n.a. (--%) were implemented fully and n.a. (--%) were implemented in a timely manner. • Many of the CAPs were initiated months, if not more than a year ago, making it impossible for the monitoring team to make a determination that they were implemented timely and fully. • In the future, Mr. McCarthy's comments should specifically and explicitly indicate whether or not all aspects and actions of the CAP were implemented <u>fully</u> and in a <u>timely</u> manner. The QA department and monitoring team engaged in a lengthy discussion about this during the onsite review. b. There was not an adequate system for tracking the status of CAPs. Of the 30 open CAPs being tracked by the facility, 0 (0%) indicated the status of the CAP. • Rather than merely indicating the CAP remained open, there should be some running commentary about status, actions, data, anticipated closure, etc. • The QAD director was just initiating a very creative and important activity. Mr. McCarthy, in addition to speaking with each responsible person each week, was also being charged with reviewing 40% of all closed CAPs to see if the corrections were maintained and the issues for which the CAP was created remained at a satisfactory level.	Noncompliance

#	Provision	Assessment of Status	Compliance
		c. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding open or closed) that was updated within the month prior to the onsite review. He graphed the number of open and the number of closed CAPs. The table and graphs were created and maintained by Mr. McCarthy. d. The QA director or section leader did present this information to QAQI Council at least quarterly.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The monitoring team will assess these metrics at the next review. a. For n.a. out of n.a. CAPs (--%), documentation showed review of their effectiveness (i.e., outcomes), and for n/a out of n/a CAPs (--%), documentation showed review of their timely completion. • Data are needed to indicate if the CAP was effective. • The QA staff maintained a table and graph showing the number of CAPs that were modified (e.g., 4 in April 2014). It was good to see the beginnings of a CAPs modification management component of the CAPs system, however, the monitoring team was unable to determine which ones were modified, how they were modified, and why they were modified. b. Of the n.a. CAPs that appeared to need modification, n.a. (--%) were modified. c. Based on a sample of n.a. completed CAPs and n.a. in process CAPs, n.a. (--%) were discussed at QAQI Council. d. For n.a. out of n/a (--%) modified CAPs, evidence was present to show timely implementation. e. For n.a. out of n/a (--%) modified CAPs, evidence was present to show full implementation.	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:** <u>Documents Reviewed</u>: o DADS Policy #004.1: Individual Support Plan Process o DADS Policy #051: High Risk Determinations o Curriculum used to train staff on the ISP process o SASSLC Section F Presentation Book o SASSLC Self-Assessment o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed. o Draft ISPs and Assessments for Individual #337 and Individual #90 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #128, Individual #116, Individual #349, Individual #279, Individual #313, Individual #119, Individual #194, Individual #287, Individual #95, Individual #285, and Individual #325. <u>Interviews and Meetings Held</u>: o Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; o Charlotte Fisher, Director of Behavioral Health Services o Adrianne Berry, Incident Management Coordinator o Rhonda Sloan, QIDP Coordinator o Joan O'Connor, Assistant Director of Programming <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 4/28/14 and 4/29/14 o Morning Unit Meeting 5/1/14 o Morning Clinical Meeting 4/28/14 o QA/QI Meeting 4/29/14 o ISP preparation meeting for Individual #255 and Individual #12 o Annual IDT Meeting for Individual #337 and Individual #90

	Facility Self-Assessment: The self-assessment had been updated on 4/17/14 with recent activities and assessment outcomes. For each provision, the facility had identified: (1) activities engaged in to conduct the self-assessment, (2) the results of the self-assessment, and (3) a self-rating. The QIDP Coordinator was responsible for the section F self-assessment. The current self-assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and provided a self-rating for each provision item. The facility continued observing ISP meetings, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. These are the same type of activities that the monitoring team looks at to assess compliance. The facility self-rated itself as being out of compliance with all provision items in section F. Findings for provisions that were audited by the facility were similar to findings of the monitoring team. For example, the monitoring team and the facility each found problems with meeting attendance, timely submission of assessments, and ensuring that action plans were developed to address assessment recommendations. The monitoring team agreed with the overall assessment of noncompliance for each provision item.
	Summary of Monitor's Assessment The facility had made little progress in developing an adequate IDT process for developing, monitoring, and revising treatments, services, and supports for each individual. Recent turnover in the QIDP department had impacted progress made during previous visits. The facility had replaced five of 17 QIDPs in the past six months. Two annual ISP meetings and two pre-ISP meetings were observed during the monitoring visit. Many improvements were noted in regards to facilitation skills and interdisciplinary discussion. The QIDP/ISP facilitator at all meetings demonstrated improved facilitation skills. All four teams engaged in better discussion of risks and support needs in relation to preferences and outcomes. It was positive to see progress made in these areas. There was little discussion at either meeting, however, regarding how the individual spent a majority of his or her day or how the team would ensure that they were involved in meaningful activities. The IDTs did not develop outcomes that would build on what the individuals were currently doing to offer new experiences or opportunities to learn new skills based on identified preferences. It was not clear that supports developed by the IDT were either meaningful or functional for the individual. At both meetings, very few revisions were made to current supports with little consideration of whether or not the support had been effective. IDTs were unable to determine the status of current supports due to a lack of documentation and consistent monitoring of services. Consequently, both IDTs continued the outcomes with little changes in supports or discussion regarding barriers to implementation. It was evident at both meetings that the facility did not have an adequate system in place to ensure that plans were implemented and supports were monitored for efficacy.

	IDTs need additional training on how to develop integrated action plans based on assessment recommendations that incorporate the individual's preferences. Additionally, IDTs need guidance on setting priorities for training and developing measurable objectives with clear directions for staff designated to implement plans. To move forward towards substantial compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review. • The facility needs to continue to track submission of assessments by discipline prior to the annual ISP meeting and address any trends of late submission with the specific department responsible for submission. • IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings and two pre-ISP meetings. The ISP facilitator facilitated the annual IDT meetings. The assignment of having ISP facilitators lead the discussion was a new process for the IDTs. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, the CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, QIDP monthly reviews, the individual's daily schedule, and ISP Preparation	Noncompliance

#	Provision	Assessment of Status	Compliance
		Meeting documentation, as available. A sample was requested of the most recently developed ISPs from each residence on campus, and eight were submitted for review. A variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. Observations of team meetings and reviews of ISPs also illustrated that the QIDP/ISP Facilitator was the team leader and responsible for ensuring team participation. A QIDP Coordinator oversaw the QIDP Department. The QIDP Educator had recently begun facilitating annual ISP meetings. The facility planned to fill the two new ISP Facilitator positions to facilitate all ISP meetings. The facility had 16 QIDPs. The facility used the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills. All 16 of the QIDPs had been deemed competent in facilitation skills. The ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the ISP facilitators in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the ISP facilitators used this template to draft portions of the ISP prior to the meeting. The facilitators came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. The QIDP Educator facilitated both annual ISPs held the week of the onsite review. The QIDP facilitated the pre-ISP meetings observed. All QIDPs observed demonstrated good facilitation skills. However, there were still a number of barriers to ensuring that the team developed a comprehensive ISP that integrated all needed services and supports. Barriers included, but were not limited to: • Assessments were still not consistently completed and available to IDT members prior to annual IDT meetings. • It was not evident that all team members were either present at meetings, or, if not physically present, had the opportunity to provide adequate input prior to the meeting. • Implementation and monitoring of supports was inconsistent. Team members were unable to determine that status of outcomes implemented the previous year. • It was not evident that data were consistently gathered and analyzed, and then used to revise or develop new supports. A sample of IDT attendance sheets was reviewed for presence of the QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed.	

#	Provision	Assessment of Status	Compliance
		QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found that the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. At both ISP meetings observed, it was noted that outcomes developed the previous year had not been implemented. There was no evidence that the QDIP was monitoring services and taking action when supports were not in place or action steps developed by the team had not been implemented. There was not an adequate monthly review process in place. As a result, it was unclear whether progress had been made on outcomes or if current supports were effective. Consequently, IDTs made very few changes in supports and services for the upcoming year. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, the facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted or when outcomes had been completed. To move forward, the facility needs to focus on ensuring that QIDPs are monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a lack of implementation, change in status, or a lack of progress.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	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 in the pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. SASSLC was using the pre-ISP process to identify assessments to be completed prior to the annual ISP meeting. The QIDP Coordinator was tracking attendance by relevant IDT members monthly. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for September 2013-February 2014. The percentages reflect attendance by those disciplines identified at the pre-ISP meetings to be required attendees at the annual ISP meeting. Attendance remained low for some disciplines. For the ISP meetings held during the review period, only 58% of the individuals attended their own meeting and only 33% included family member participation.	Noncompliance

#	Provision	Assessment of Status	Compliance

Team member	
Individual	58%
LAR	46%
Family/Advocate	33%
DSP	36%
QIDP	100%
Psychologist/BA	73%
RN	83%
Occupational Therapist	32%
Physical Therapist	57%
Speech Therapist	78%
Dietician	16%
Primary Care Provider	32%
Psychiatrist	16%
Dental Services	No data
Pharmacy	1%
Day Programming/Vocational Services	68%
Active Treatment Staff	64%
Home Manager	24%
Local authority	71%

Six of eight ISPs submitted included a pre-ISP packet that designated staff members required to attend the annual ISP meeting. Review of six ISP attendance sheets confirmed that there were key staff missing who were identified as relevant participants in six of six (100%) of the annual meetings in the sample. The sample was Individual #128, Individual #116, Individual #349, Individual #279, Individual #313, and Individual #325. None of the ISPs were developed by an appropriately constituted IDT.

- At the annual ISP meeting for Individual #313, relevant team members identified at the pre-ISP meeting that did not attend the meeting included Individual #313, his family, his PCP, his active treatment staff, and his home manager.
- Individual #325's day program staff did not attend his meeting.
- Vocational program staff and DSPs were not in attendance at Individual #279's annual ISP meeting.
- Key team members not in attendance at Individual #349's annual ISP meeting included his DSP, day program staff, and home manager.
- Relevant team members not in attendance at Individual #116's annual ISP meeting included her vocational staff, physical therapist, and the local authority.
- Individual #128's LAR, dietician, psychiatrist, dental staff, active treatment staff, and PCP did not attend his annual ISP meeting.

In zero of six ISPs (0%), for any team members not physically present at the IDT meeting,

<table>
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<tr><td></td><td></td><td>was there evidence of their participation in the development of the ISP.

The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process. Relevant team members should be identified at the pre-ISP meeting; then the facility should use that information to track actual attendance by relevant team members at the ISP meeting. When team members cannot attend the meeting, the ISP should note efforts to get input from those team members prior to the annual meeting.</td><td></td></tr>
<tr><td>F1c</td><td>Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.</td><td>DADS Policy #004.1 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration.

Annual ISP preparation meetings were required to be held approximately 90 days prior to the annual ISP meetings. At the ISP preparation meeting, the IDT was to identify the assessments that were required for the annual ISP meeting. The state policy required that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting for review by all IDT members. The assessments were to be used by the QIDP to develop an ISP Guide prior to the ISP annual meeting.

According to data collected by the facility, only 30% of the ISPs held 9/1/13-2/28/14 were preceded by a pre-ISP meeting. Two ISP Preparation meetings were observed. The IDT completed a checklist at both meetings indicating what assessments would need to be completed prior to the annual ISP meeting.

The facility was gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of discipline specific assessments for September 2013 through February 2014 indicated that there had been improvements in the number of assessments submitted prior to ISP planning meetings for seven of 12 disciplines. The chart below shows assessment submission rates for that time period.

<table>
<tr><th>Discipline</th><th></th></tr>
<tr><td>Clinical</td><td>44%</td></tr>
<tr><td>Functional Skills Assessment</td><td>33%</td></tr>
<tr><td>Dental</td><td>99%</td></tr>
<tr><td>Dietary</td><td>86%</td></tr>
<tr><td>OT/PT</td><td>92%</td></tr>
<tr><td>Communication</td><td>81%</td></tr>
<tr><td>Audiology</td><td>44%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Nursing	79%
Pharmacy	98%
Behavioral Health	45%
Psychiatry	23%
Day Programming/Vocational	56%

A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Six of the ISPs submitted to the monitoring team included the pre-ISP packet. The pre-ISP determination of assessments needed prior to the annual IDT meeting list was compared to assessments submitted. The sample was Individual #128, Individual #116, Individual #349, Individual #279, Individual #313, and Individual #325.

- Individual #128 did not have an updated behavioral, psychiatric, dental, functional skills, or vocational assessment.
- Individual #116 did not have an updated medical, behavioral, dental, functional skills, or day program assessment.
- Individual #349 did not have an updated behavioral, dental functional skills or day program assessment.
- Individual #279 did not have an updated dental, behavioral, OT/PT, or functional skills assessment.
- Individual #313 did not have an updated medical, behavioral, dental functional skills, vocational, or pharmacy assessment.
- Individual #325 did not have an updated medical, behavioral, dental, functional skills, day program, or pharmacy assessment. His nursing assessment was submitted late and his nutritional assessment was not dated.

In six of six (100%), the team considered what assessments the individual needed and would be relevant to the planning process. The team defined the assessments that were needed for the annual meeting during the ISP Preparation meeting.

In zero of six (0%), the team obtained the needed relevant assessments. None of the individuals in the sample had <u>all</u> assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting.

Functional skills assessments were not timely and, in general, assessments were not consistently used to develop SAPs (see S2).

Assessments from various disciplines were reviewed to determine if the assessments were submitted and if they included recommendations that were adequate for planning. Assessment should provide information/recommendations that would guide the IDT to support the individual and develop a comprehensive plan to help the individual learn or

#	Provision	Assessment of Status	Compliance
		develop a skill, achieve an outcome, or address a medical or behavioral issue. Findings were: <u>Behavioral Health Services</u> Functional assessments were completed and timely for all individuals with PBSPs. The quality of those assessments, however, was not consistently adequate (see K5). There was some evidence that functional assessments were redone in response an increase in problem behavior. Preference assessments were not completed for all individuals at SASSLC. <u>OT/PT/Communication</u> 100% of the assessments reviewed for OT, PT and speech identified preferences and needs. A number of the assessments provided SAPs for implementation by therapies, though only three individuals were listed as receiving direct OT or PT, and four individuals received direct communication-related therapy. Most suggested SAPs for implementation by the DSPs as integrated throughout the day or during routine activities based on current skill levels and potential for learning new ones. There were communication strategies outlined for every individual to expand or enhance their level of communication and social interaction. <u>Nursing</u> Comprehensive Nursing Assessments did not consistently identify the individual's strengths, preferences, or needs. For example, Individual #101's preferences did not include how she participated in her own health care related to reoccurring skin integrity issues. Nor did nursing assessments consistently provide recommendations that would guide the IDT to support the individual and address medical issues. For example, Individual #263's Comprehensive Nursing Assessment documented the changes from the previous quarterly nursing assessments weights of being between 57 and 59.8 pounds over his EDWR. However, there were no recommendations provided in the Comprehensive Nursing Assessment under the Recommendations section for addressing the overweight issue. At both ISP meetings observed, the team determined that some assessments were not adequate for planning. Both IDTs ended up requesting additional assessments, therefore, the team was unable to fully develop supports at the meeting. For example, • Individual #337's current assessments listed autism and dysphagia among her diagnoses. IDT members were not sure about the accuracy of those diagnoses. Both diagnoses impacted the development of supports, thus, the team was unable to fully develop adequate supports without accurate assessments. It was determined that further assessment for planning was needed.	

#	Provision	Assessment of Status	Compliance
		The facility was not in compliance with this item. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months 1. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning.	
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 described in F1c, assessments required to develop an appropriate ISP meeting were not always done in time for IDT members to review each other's assessments prior to the ISP meeting. QIDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and then information from assessments is used to develop plans that integrate all supports and services needed by the individual. In zero of two (0%) ISP meetings observed, recommendations from assessments were used to develop plans that would provide a broader range of experiences and lead to the development of new skills. It was not clear in either meeting how the IDT established priorities for training. Outcomes were based on activities that the individuals already had an opportunity to participate in without consideration of potential opportunities for growth. For example, at Individual #337's meeting, • The team acknowledged that she was currently retired and enjoyed retirement activities. Her outcome for the previous year was to participate in group activities. The team agreed that her retirement outcome this year would be changed to "participates in group activities for 15 minutes." The IDT did not consider retirement outcomes that would offer her further opportunities to develop new skills or interests. Her leisure outcome for the previous year was to attend activities at DC monthly. The team agreed to revise the frequency to weekly. Again, there was no discussion regarding what activities might be meaningful to her or what new skills or interest she might develop through this activity. Individual #90's assessments identified her support needs and preferences, however, the IDT failed to use the information to develop meaningful supports and programming. For example, • The team agreed to continue her outcome to attend leisure events weekly without using her assessments to determine what supports were needed and what specific activities might be meaningful to her. • Her outcome to spend time outside was continued, but the team agreed to lower the criteria (number of days) because she did not meet criterion the past year.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The team did not discuss revising supports to ensure more frequent implementation. The adequacy of integration of recommendations into the ISP for specific disciplines is discussed in detail in other sections of this report and some comments are below. Recommendations from assessments were consistently used to develop PBSPs plans for individuals (see K9). For example, functional assessments were consistently used to develop PBSPs to address behavioral issues (see K5 and K9). On the other hand, only 52% of SAPs were based on clear needs identified in assessments (see S2). Most nursing assessments did not contain statements that were used to develop services, and/or supports for the individual from the assessments. For example: Individual #338, who had experienced a weight gain, evaluation section of the assessment noted "She eats and sleeps well and her weight has increased." A PNMP was developed for each individual to address identified PNM-related risks such as falls or choking. When assessments were completed after the annual IDT meeting, it was not always evident that the IDT met to review the assessment and incorporate recommendations into the ISP. For example, • Individual #349's IHCP included action steps to consult with dental staff regarding tooth extractions and to request an evaluation by the physician regarding medications. There was no evidence that the team met following either consultation to discuss findings and revise supports, if appropriate. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and all recommendations from assessments are used to develop and revise supports as needed.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	In the new ISP format, discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with a consensus opinion by team members from various disciplines. Any barriers to community placement were to be addressed in the ISP. See section T regarding the quality of discipline specific determinations. None (0%) of the individuals in the sample were offered a range of opportunities to participate in meaningful activities in the community.	Noncompliance

#	Provision	Assessment of Status	Compliance
		None (0%) of the individuals in the sample had adequate access to the use of community services and community supports (e.g., hair salons, gyms, banks, churches, pharmacies). None (0%) of the ISPs in the sample indicated that the individual was adequately integrated into the community (i.e., regularly participated in activities in the community and engaged with others in the community, had memberships, hobbies, and interests, works/volunteers, or contributed to the community in some way). It was not evident that the facility provided day programming opportunities in the community. General outcomes were written to attend activities in the community without describing what training would occur while there. At both IDT meetings observed, the IDT engaged in good discussion regarding community living options. Both IDTs determined that lack of exposure to the community as a barrier to choosing a living option. The IDTs developed outcomes for further exposure to living options through attendance at provider fairs and visits to community group homes. This was a continuation of outcomes developed the previous year for both individuals. It was noted that outcomes had not been consistently implemented and that little progress had been made. The IDTs agreed to continue the outcomes without discussing barriers to achieving progress during the previous year. The IDTs did not consider other outcomes that would encourage community integration for further exposure to new things in the community. The sample of ISPs reviewed did not include good documentation regarding the living options discussion. Although in most cases, ISPs documented recommendations from individual team members, it was not evident that those recommendations were used for planning. Specific barriers were not always identified or addressed when identified. For example: • Individual #116's ISP documented the opinions of each discipline regarding whether or not supports could be provided in a less restrictive environment. Each discipline determined, through the assessment process, that supports could be provided in the community. The living option summary in her ISP stated that discipline members (independent of the resident/family) determined that she could not be served in a less restrictive environment. Moving forward, it will be important to ensure that discussion is adequately documented in the ISP itself. Eight ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #128, Individual #116, Individual #349, Individual #279, Individual	

#	Provision	Assessment of Status	Compliance
		#313, Individual #119, Individual #194, and Individual #325. None (0%) of the ISPs included meaningful training opportunities in the community. Individual #194's ISP did not include any outcomes. Community based outcomes for the other individuals in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #325 had a community based outcome to "attend an of campus activity during the next 12 months." • Individual #116 and Individual #349's ISPs did not include any outcomes that were to be implemented in the community. There was little focus on providing supported employment or volunteer opportunities in the community for individuals at the facility. The facility reported that six of 238 individuals (3%) were working in the community. None (0%) of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	
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;	In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs engaged in a discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting and attempted to develop plans to include the individual's preferences. Teams were not adept at using preferences to build on new training opportunities for	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals. Preferences were typically based on a limited range of activities that the individual had the opportunity to participate in at the facility. Outcomes related to preferences were often general statements that ensured that the individual would have opportunities to continue to participate in those same activities with little discussion on how those preferences could be expanded or used to develop new skills. Lists of preferences in the ISPs in the sample were individual specific. Preferences were used to develop outcomes for participation in preferred activities. IDTs, however, were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences. ISPs in the sample provided few opportunities to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on specific interests, or exploring volunteer or work opportunities. In a review of eight recent ISPs, none (0%) offered specific training to be provided in the community. While the community was occasionally listed as a possible training site for outcomes, training was not designed specifically for functional training in the community. As noted in F1e, outcomes for training offered opportunities for visits in the community, but none were focused on gaining specific skill building opportunities. IDTs were beginning to prioritize support needs, particularly in terms of communication and healthcare needs. Teams were still struggling with how to integrate these support needs into functional objectives based on preferences. To move in the direction of substantial compliance, the monitoring team recommends that the facility focus on developing individual specific outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related	A sample of ISPs, IHCPs, and skill acquisition plans (SAP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. As noted in F1e, none of the ISPs reviewed included measurable outcomes to address barriers to community placement. The monitoring team found that many outcomes were not written in a way that staff could measure progress towards completion and/or that plans did not provide enough information to ensure consistent	Noncompliance

#	Provision	Assessment of Status	Compliance
	to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. For example, • Individual #116 had an action step in her ISP that stated "will sit in her preferred recliner during her leisure time at least three times per week." The frequency of implementation was "as scheduled." There were no staff instructions to ensure consistent implementation or guide staff in supports need, best time for implementation, length of implementation, etc. • Individual #287 had an action step to "organize her room with no more than three verbal prompts." It was not clear what would constitute a successful attempt at "organizing" her room. • Individual #142 had an outcome "to engage in social skills continually throughout each month for 12 consecutive months." It was not clear what staff would measure for successful completion of this outcome. • Individual #47 had an outcome that stated she would "be provided an effective PNMP, TIVA prior to dental clinic visits annually, and BM program during the next 12 months." This outcome should have been broken down into multiple measureable outcomes. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and I also address the writing of measurable strategies to address health care risks. It was not always evident that appropriate supports were developed when IDT members identified needs or barriers to achieving outcomes. PBSPs generally included individualized measurable treatment strategies based on identified needs from functional assessments. On the other hand, only 52% of SAPs were based on clear need identified in assessments (see S2). The monitoring team found that PNMPs were modified numerous times throughout the year based on need and changes in status. There were measurable goals outlined for all direct interventions, outcomes related to PNM-risk areas associated with interventions outlined in the PNMP, and measurable goals suggested for SAPs recommended based on skill levels and identified needs. Appropriate supports were not always developed when IDT members identified needs or barriers to achieving outcomes. For example, Individual #321's admission IPNs gave the appearance that the admission meeting was not productive for supporting the individualized for addressing all the necessary supports to include treatment or strategies regarding his aggressive behavior in his new setting. The records indicated	

#	Provision	Assessment of Status	Compliance
		the ISP was held on 4/22/14. The record did not contain the ISP and completed IRRF with risk ratings. Overall, the nursing summaries/analyses were not consistently documented regarding individual's health status in relation to identify their risk rating, nursing diagnosis, and nursing problems as to whether or not they were attaining their health goals. Section T elaborates on 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. As noted in F1e, ISPs did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. The facility was not in compliance with this provision.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. The development of action plans that integrated all services and supports was still an area with which the facility struggled. Action plans to address outcomes in both the IHCP and SAPs typically included reference to ancillary plans (i.e., PNMP, communication plans, PBSP), however, strategies from those plans were not typically integrated into supports with strategies specific to achieving outcomes. The PNMP was not submitted as a part of the ISP for any of the ISPs requested, thus, it did not appear to be considered an integrated part of the ISP. SAPs in the sample reviewed did not include strategies or recommendations developed through the assessment process. For example, Individual #194 had a vocational outcome to improve her work skills by remaining on task. Behavioral strategies from her PBSP and recommendations from her communication assessment should have been included in her skill acquisition plan, but were not. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and IHCP. For the most part, these continued to be stand alone plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		When developing the ISP for an individual, the team should consider all recommendations from each discipline, along with the individual's preferences, and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Observation at annual ISP meetings and pre-ISP meetings indicated IDTs were engaging in better discussion regarding the need to integrate supports into a comprehensive plan. This was particularly true in developing supports to address risks identified by the IDT. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, some action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. Each action step should be a measurable action the individual will perform, include the frequency, method of documentation and reporting requirements, and designate the assigned person for implementing and reviewing progress. A sample of outcomes was reviewed: • Individual #313 (three outcomes/eight action steps) • Individual #128 (five outcomes/13 action steps) • Individual #279 (five outcomes/nine action steps) As noted in F2a2, few outcomes and action steps were written in terms of measurable action that the individual would perform to complete the objective. For example: • Individual #313's ISP include an identical action step that stated "will have an IHCP" for each of his three outcomes. Supports included in his IHCP should have been integrated into strategies for specific action steps to achieving his outcomes. • Individual #128 had an outcome to "maintain or increase" positive relationships. It was not clear what would constitute successful completion of the outcome. His vocational outcome was not measurable. One of his action steps was to successfully transition to a new home. This action step was not measurable and did not include support strategies.	Noncompliance

#	Provision	Assessment of Status	Compliance
		IHCP action steps were generally brief statements of action to address the risk or references to additional plans (i.e., PNMP, PBSP). Most did not include methodology or criteria for monitoring effectiveness of intervention. As noted in F2a3, the PNMP was not submitted as part of the ISP. Additionally, each discipline will need to ensure that assessments are completed prior to the annual ISP meeting to ensure training strategies are developed using current recommendations from each discipline. <u>Time frame for completion</u> A sample of ISPs was reviewed to verify that action steps included a time frame for completion. Four of 30 (13%) included projected completion dates. Exceptions were: • Individual #313's action steps did not include completion dates. • Four of 13 of Individual #128's action steps included completion dates. For those four, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. • Individual #279's action steps did not include completion dates. <u>Staff responsible</u> Outcomes in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. Many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence in key areas of their lives. For example, outcomes did not address increasing independence in routine household activities, such as laundry, yard work, and meal preparation. For the SAPs available for review, program developers were doing a better job of using individualized communication and behavioral strategies to develop teaching strategies. IDTs were doing a better job of integrating recommendations of each discipline into the	Noncompliance

#	Provision	Assessment of Status	Compliance
		outcomes, action plans, and teaching strategies. None (0%) of the ISPs in the sample included adequate outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were general in nature and did not address barriers to working in the community. To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	
	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.	DADS Policy specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Health Care Plans included similar information. <u>Data to be collected</u> The type of data to be collected and the frequency of implementation were to be in the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection to permit the objective analysis of progress. <u>Frequency of data collection</u> For the sample described in F2a4, 24 of 30 (80%) action steps included the frequency of implementation. Most action steps indicated how often the action step should be implemented in terms of daily, weekly, monthly, quarterly, or annually. Six of Individual #128's outcomes stated "ongoing" as the frequency. Program developers should list frequency in concrete terms, even specifying the day of the week and time for training when feasible to ensure consistent implementation. <u>Person responsible for collecting and reviewing data</u> Outcomes in the sample included designation of which staff /discipline would be responsible for implementation of the outcome and which staff would monitor the plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility was not in substantial compliance with this provision.	
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 F1, adequate assessments were often not completed prior to the annual meetings. When assessments were recommended by the team, it was not evident that the ISP was revised to include recommendations once the assessment was completed. To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are integrated throughout the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of 16 individual records was reviewed in various homes at the facility. Current ISPs were in place in 15 (94%) of records reviewed, however, none of the ISPs included the IHCP, thus, plans were incomplete. Data reviewed for ISP submission between 9/1/13 and 3/31/14 indicated that only 41% of the ISPs developed within that timeframe were filed in the active record within 30 days of development. As noted in other sections of this report, the monitoring team found that outcomes were rarely written in measurable terms, so that those monitoring the plan could determine when progress was made or if the outcome was completed. Additionally, teaching and support strategies were not comprehensive enough to ensure that staff knew how to implement the outcome and provide appropriate supports based on assessment recommendations. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. All plans integrated into the ISP should be accessible to staff as one comprehensive document. 2. ISPs should be available for staff to implement within 30 days of development. 3. All outcomes should be written in clear, measurable terms. 4. Teaching and support strategies should provide a meaningful guide to staff responsible for plan implementation. 5. ISPs should be accessible to staff within 30 days of the development of the plan.	Noncompliance
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	QIDPs were assigned overall responsibility for monitoring services and supports in the ISP. The facility did not have a consistent monthly review process in place to review all supports. A sample of QIDP monthly reviews for the past six months was requested for 10 individuals with some of the most recent ISPs. A full set of six months of monthly reviews was not available for any of the individuals in the sample (0%). Six individuals (60%) in the sample had no QIDP monthly reviews for the six month period reviewed. The facility recently appointed an ISP facilitator to facilitate ISP meetings. The QIDP	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Coordinator was planning to hire/appoint a second ISP facilitator in the near future. The rationale for this reorganization included allowing QIDP to spend more time monitoring supports and services. The facility began using a database to track the submission of monthly reviews in February 2014. For behavioral health services, the monitoring of services and supports was improving. For example, monthly PBSP progress notes were completed and indicated that action consistently occurred when the individual outcomes were not achieved (see K4) Nursing services and supports were not consistently monitored and specific progress or regression was documented. For example, Individual #217, on eight occasions, required a suppository to treat her constipation due to not having a bowel movement in three days. The Nursing Comprehensive Assessment failed to include any recommendations for addressing the individuals' problems with chronic constipation. Supports were not always modified when the individual experienced a change of status, regression occurred, and/or outcomes were not achieved. For example, Individual #47's Comprehensive Nursing Review documented she had an increase in falls this year, with multiple injuries, for which the assessment failed to sufficiently assess the previous year's supports. Furthermore, the recommendations were inadequate for suggested interventions; rather, the recommendation stated, "current supports should continue." The PNMP was monitored consistently based on the recommended frequency suggested by the therapist and outlined in the assessment. By report, these were approved by the IDT, but this was not always included in the ISP itself. Effectiveness monitoring was conducted frequently for various aspects of the PNMP, but it could not be determined if this occurred for the entire PNMP on a routine basis. The QIDP Coordinator acknowledged that there was not yet an adequate monthly review process in place. The monitoring team found that the current IDT process was not adequate for implementing, assessing, and monitoring of services for individuals. To move forward towards compliance, 1. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues or consider revising supports. 2. Plans should be updated and modified as individuals gain skills or experience regression in any area.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible	In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document.	Noncompliance

#	Provision	Assessment of Status	Compliance
	for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	The facility was utilizing the Q Construction Assessment Tool to assess QIDPs for competency in facilitation skills. All (100%) QIDPs had been deemed competent in facilitation skills. Progress had been made in facilitation of meetings observed the week of the monitoring visit. QIDPs were still learning to use the new statewide ISP format to develop the ISP. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at SASSLC. It would be beneficial for the facility to seek additional outside training and consultation from the state office on developing person-centered ISPs. All new employees were required to complete Supporting Visions, the statewide training on the ISP process. Data collected by the training department for new employees hired through February 2014 showed 100% of all new employees completed training on the ISP process. The facility did not have a consistent process in place for providing individual specific training to staff on implementing ISPs. The facility trend report regarding injuries indicated that lack of staff training and/or failure of staff to implement supports correctly contributed to a number of injuries at the facility. Residential Coordinators were assigned to attend ISP meetings and train DSPs on the resulting plans. Staff instructions were provided to DSPs as a guide to implementing supports. Staff instructions, however, for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments. To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	A sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available in 15 of 16 records reviewed. Plans available, however, did not include the IHCP. IHCP are a significant part of the ISP document. Without the IHCP, staff did not have the information needed to provide safe supports to individuals. As noted throughout section F, IDTs were still not ensuring that plans were monitored for efficacy and revised when outcomes were met or when there was regression or lack of progress towards outcomes. The monitoring team reviewed data in regards to ISPs held September 2013 through March 2014. A list of ISP dates was provided with the date the ISP was due and the date the ISP was filed (document V.10). During this time period, 102 of 108 (94%) annual ISP meetings were held within 365 days of the previous annual ISP meeting. The facility reported that only one of six (16%) of the ISPs developed for individuals newly admitted	Noncompliance

#	Provision	Assessment of Status	Compliance
		to the facility occurred within 30 days as required by state policy. 44 of 108 (41%) of the ISPs were filed within 30 days of development. The facility reported a decrease in the timely filing of newly developed ISPs over the six month review period due to turnover among the QIDP staff. An adequate review process will need to be in place to ensure that supports are revised as needed. As previously noted, at both ISP meetings observed, the IDT acknowledged that little progress had been made on most outcomes and some outcomes were not implemented for the previous year. The IDT should have met prior to the annual meeting and revised outcomes and supports when it was noted that outcomes were not implemented or lack of progress was noted. The facility needs to continue to focus on ensuring that ISPs are accessible within 30 days of development. An adequate review process needs to be implemented that leads to the revision of plans when outcomes are met, individuals experience a change of status, there is a lack of progress towards the accomplishment of outcomes, or when regression is noted.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility was using an audit system similar to the monitoring team's review. Tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality assurance activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on data collected and self-assessment findings. It was too early to determine if corrective action plans were effective.	Noncompliance

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o SASSLC Standard Operating Procedure: 200-5C, Facility Integration of Clinical Services o SASSLC Policy, Minimum Elements of Clinical Care, 3/25/14 o SASSLC Self-Assessment o SASSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o David Espino, MD, Medical Director o Libby Tolle, RN, Medical Compliance Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Daily Clinical Services Meeting
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described, for each of the two provision items, activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For provision G1, there were five activities listed and four results were reported. The ISP attendance for the primary care providers was reported. Data for other clinicians were not. It was also documented that there was no system to ensure that the recommendations of the clinical disciplines were incorporated into the plans of the individuals. For provision G2, the self-assessment reported compliance with documentation of agreement or disagreement with the recommendations of the consultant on the consultation form. However, state policy required all documentation related to the consultation to be made in the IPN.

	In moving forward, the monitoring team recommends that the medical director review this report. For each provision item in this report, the medical director should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Again, the state draft policy should also be reviewed for additional guidance. The facility found itself in noncompliance with both provision items. The monitoring team agrees with the facility's assessment.
	Summary of Monitor's Assessment: Throughout the conduct of the review, the monitoring team found some evidence of integration of clinical services. No true progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services. However, some meetings were expanded or included more discussions that had the potential to improve integration of clinical services. The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. He reported on integration activities, but the discussion was limited to the meetings of the disciplines. The monitoring team has stressed that meetings do not guarantee that services are delivered in an integrated manner and the monitoring team expects to learn of the outcomes of the meetings Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted. Continued work in this area is needed. The monitoring team expects that as additional guidance is provided from state office in the form of a finalized policy, the facility will have greater clarity on how to proceed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The facility continued to work on delivering services in an integrated manner. However, there were no activities that specifically focused on improving in this area. This was quite evident in the fact that the self-assessment did not have any metrics capable of measuring integration of clinical services. Staff did not seem familiar with the facility's approved integration policy and it was not submitted for this review. The monitoring team met with the medical director, who served as lead for sections G and H, and the medical compliance nurse, to discuss the status of sections G and H. The medical director reported that medical staff participation in the ISPs improved. For the reporting period of September 2013 to February 2014, the primary care providers attended 51 of 121 (42%) ISPs. This was nearly twice the attendance observed during the previous compliance review. He also reported that no data were available for the	Noncompliance

#	Provision	Assessment of Status	Compliance
		other clinical disciplines even though it was understood that section G addresses integration of all clinical services. Weight management was provided as one example in which the clinical disciplines worked together to provide integrated services. The monitoring team reviewed local and state procedures, conducted interviews, completed observations of activities, and reviewed records and data to determine compliance with this provision item. The monitoring team also observed a variety of activities designed to foster integration of clinical services. These activities included daily meetings, periodic meetings, and committee meetings. The following are some examples of the observations of the monitoring team: • Daily Clinical Services Meeting - The monitoring team attended several of these meetings and found that they were well attended during the week of the review. The events of the past 24 hours were discussed, including hospital admissions, transfers, use of emergency drugs, clinic consults, restraints, weight changes, and adverse drug reactions. Dental and behavioral health reports were provided as well. • The OTs, PTs, and SLPs completed comprehensive assessments and assessments of current status collaboratively on at least an annual basis as well as in the interim for acute concerns or changes in status. Assessments were also completed annually via collaboration with psychology related to communication and sensory issues that impacted behavior. The PNMT members represented OT, PT, SLP, RN, and RD. Physicians routinely attended and actively participated in these meetings • When quarterly psychiatry clinics or other psychiatric clinical consultation occurred, there were generally members of the IDT present for integration, including behavioral health, nursing, and therapy services. During the monitoring visit, two psychiatry clinics were observed. While there was good communication between the providers in clinic, administrative challenges prevented adequate integration. For example, the lack of IT infrastructure in psychiatry clinic prevented the psychiatrist from reviewing the MOSES and DISCUS evaluations during clinic. • Behavioral health services demonstrated functional integration with psychiatry. • The Medication Variance Committee was intended to be a multidisciplinary committee. For much of 2014, however, the committee did not function in that manner and meetings were limited to nursing services. The last two meetings were multidisciplinary and the appropriate clinical disciplines participated. • One of the most notable deficiencies of this review was the lack of strategies and intervention to address the barriers to dental treatment and the lack of involvement of behavioral health services in helping individuals to overcome barriers to treatment. This area will require continuous collaboration between	

#	Provision	Assessment of Status	Compliance
		nearly all clinical disciplines in order to make significant progress. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should track attendance of all disciplines at ISP meetings. 2. The facility should address the issues noted above. 3. The state should provide additional guidance in the form of a policy.'	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The medical department implemented a new process related to consultations in February 2014. This process involved several individuals. The clinic nurse made the appointments and provided the lab nurse with the information to enter into the database. If the individual returned from the appointment without the written consult, the administrative assistant telephoned the consultant's office requesting that the consult be faxed or mailed. A new consultation form was implemented in February 2014 that allowed the PCP to agree or disagree with the recommendations of the consultant and refer the recommendations to the IDT. The change in facility process did not require the PCP to document this information in the IPN. As noted in the October 2013 report, state policy required documentation in the IPN. The monitoring team provided specific recommendations to achieve compliance with state policy and the Settlement Agreement. The implementation of the new consultation acknowledged that the PCP reviewed the consult, but did not comply with state policy. The consults and IPNs for 10 individuals whose records were reviewed as part of the record sample were requested. A total of 50 consults completed after October 2013 and included in the active records of the record sample were reviewed: • 0 of 50 (0%) consultations documented in the IPN included the requirements of explaining the significance of the consult findings (summary), agreement/disagreement, and a decision regarding IDT referral Most providers documented concise summaries of the consultations that provided adequate information. Providers were fairly consistent with this documentation. They did not document agreement or disagreement nor did they indicate the need to refer to the IDT because the current process required that to be noted on the consultation form. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the	Noncompliance

#	Provision	Assessment of Status	Compliance
		recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The monitoring team recommends that IPN documentation include (a) the required summary statement regarding the reason for the consult and significance of the findings, (b) agreement or disagreement with the recommendations, and (c) the need for IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented. It is further recommended that that the PCPs always notify the IDT when there is a disagreement with the recommendations of the consultant. 2. The monitoring team also recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., Gyn Consult, 2/1/14). 3. DADS should develop and implement policy for Provision G2.	

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o SASSLC Standard Operating Procedure: 200-5C, Facility Integration of Clinical Services o SASSLC: Minimum Common Elements of Care o SASSLC Self-Assessment o SASSLC Provision Action Plan o SASSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes Interviews and Meetings Held: o David Espino, MD, Medical Director o Elizabeth Tolle, RN, Medical Compliance Nurse o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted two documents: the self-assessment and the action plan. The self-assessment presented a series of activities that were conducted for each item along with the results of activities and a self-rating, however, the activities of the self-assessment did not align with the key items presented in the facility's section H policy. Furthermore, the activities sometimes did not appear to be the most appropriate activities for the provision. For example, provision H1 addresses the timeliness and quality of assessments. The self-assessment listed the development of clinical indicators, which would have been more appropriate for several other provision items of this section rather than section H1.

	To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations. It is also recommended that the medical director review the proposed state guidelines and local policy since they both include metrics for assessing compliance with this provision. The facility found itself in substantial compliance with provision H2 and H7 and in noncompliance with all other provision items. The monitoring team found the facility in substantial compliance with H2. The monitoring team found the facility in noncompliance with provisions H1, H3, H4, H5, H6, and H7.
	Summary of Monitor's Assessment: The medical director continued to serve as facility lead for this provision. There was minimal progress observed in this provision. The progress that was seen was a result of work that occurred in the development of the medical quality program and other areas. If more effort had been made in these areas, further progress would have been seen in section H. To that end, there were no identifiable efforts focused on section H. As usual, during the week of the compliance review, the monitoring team conducted a meeting with facility staff to discuss to status of provisions G and H. The medical director and medical compliance nurse participated in the discussions. The facility continued to track assessments centrally. Each department also tracked assessments. There was no information available on the quality of assessments and tools had not been developed. Interval assessments were not addressed. The facility continued its Medical Quality Improvement Committee and much of section H was linked to data derived from that committee. As noted, progress in the medical quality program will likely translate into progress in section H because much of section H is about quality.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The state office policy, which remained in draft, required each department to have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. During the discussions with the medical director, he reported that a centralized database, maintained by QA, tracked all assessments. The self-assessment documented compliance rates, as reported by the data analyst, for a number of clinical disciplines. The data submitted in the self-assessment are summarized in the table below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Annual Assessments 2013 - 2014						
	Sep	Oct	Nov	Dec	Jan	Feb
No. of ISPs	17	23	21	18	21	17
No. of Psychiatry PTs	8	10	13	11	5	8
Discipline	Number (%) Submitted On Time					
Audiology	8 (47.1%)	8 (34.8%)	13 (61.9%)	13 (72.2%)	1 (4.8%)	8 (47.1%)
Speech	13 (76.5%)	21 (91.3%)	20 (95.2%)	16 (88.9%)	19 (90.5%)	15 (88.2%)
Dental	17 (100%)	23 (100%)	21 (100%)	18 (100%)	21 (100%)	17 (100%)
Dietary	17 (100%)	22 (95.7%)	19 (90.5%)	15 (83.3%)	12 (57.1%)	16 (94.1%)
OT/PT	13 (76.5%)	22 (95.7%)	19 (90.5%)	18 (100%)	19 (90.5%)	16 (94.1%)
Nursing	12 (70.6%)	19 (82.6%)	17 (81%)	14 (77.8%)	19 (90.5%)	12 (70.6%)
Medical	11 (64.7%)	13 (56.5%)	11 (52.4%)	4 (22.2%)	5 (23.8%)	8 (47.1%)
Pharmacy	17 (100 %)	23 (100%)	21 (100 %)	18 (100 %)	21 (100%)	17 (100%)
Psychiatry	4 (50%)	1 (10%)	6 (37.5%)	5 (35.7%)	3 (27.3%)	4 (33.3%)
Beh. Health	7 (41.2%)	16 (69.6%)	10 (47.6%)	5 (35.7%)	10 (47.6%)	6 (35.3%)

There continued to be many disciplines with significant deficiencies. Some disciplines with 365-day requirements continued to have ISP dates used to measure compliance. For example, state guidelines required completion of dental assessments every 365 days, but the data above did not reflect that requirement. While the facility was tracking the timeliness of scheduled annual assessments, the quality of these assessments was not evaluated. Even though the data reflected rather low compliance scores for several disciplines, the monitoring team was not made aware of any corrective action plans to remediate these deficiencies.

The facility reported that all psychiatry and pharmacy quarterly assessments were completed in a timely manner. There were no data submitted for the Quarterly Medical Summaries, which were required by the Health Care Guidelines, and no data were submitted related to the quality of the scheduled quarterly assessments.

#	Provision	Assessment of Status	Compliance
		There were no data reported for interval assessments, such as post hospital assessments, done by the primary care physicians, nursing, and PNMT nurse. There were also no data related to post restraint assessments completed by pharmacy and psychiatry or the nursing assessments required after serious injuries. The primary care provider attendance at post-hospital ISPAs was reported, however, attendance at the meeting is not documentation of the actual assessment. This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, and reviewed assessments and facility data. The results of those activities are summarized here: • For a sample of 15 AMAs, compliance with timely completion was 86%. Assessments were timely based on the 365-day requirement. • The PCPs were completing Quarterly Medical Summaries, however this was being inconsistently done and one PCP appeared not to complete the summaries. • Quarterly Drug Regimen Reviews were completed in a timely manner and were thoroughly done. This is discussed in further detail in section N2. This was a slight decrease from the October 2013 compliance review. • The nursing department had begun to implement the format required by state office for the Comprehensive Nursing/Quarterly Nursing assessments. It was apparent that training was needed to ensure quality of the assessments because Annual Nursing Comprehensive/Quarterly Nursing assessments included the individual response to the effectiveness of his or her medications and treatments and plans of care. For the 10 records reviewed, the majority of the nursing assessments failed to sufficiently summarize the individual's response or other identified nursing problems to care plans. • OT, PT, and SLPs conducted annual assessments for most individuals as they were provided at least a PNMP. Additionally, post-hospitalization assessments were conducted by the clinicians on a routine basis. The PNMT nurse also conducted a post-hospitalization assessment for individuals hospitalized with a PNM-related issue. In many cases, this was redundant and the RN was encouraged to collaborate on this with the hospital liaison and the individual's nursing case manager. Additional interim assessments were conducted by OT, PT, and SLP for individuals with identified changes in status that did not necessarily require hospitalization. These served to determine if changes in the PNMP or other supports were needed. • For the previous monitoring report, SASSLC psychiatry staff provided a list of 58 comprehensive psychiatric evaluations (CPE) per Appendix B guidelines that were completed as of 8/29/13. Since the previous review, an additional 13 CPEs	

#	Provision	Assessment of Status	Compliance
		were completed for a total of 71. Given that 154 individuals received treatment via psychiatry clinic, 54% of individuals still required CPE. Given the data provided, it was not possible to determine the timeliness of quarterly psychiatric clinic. • There was improvement in this area: o 84% of individuals had full psychological assessments o 100% of individuals had annual psychological assessments o 100% of individuals with a PBSP had current functional assessments o Not all individuals had preference assessments <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. To move in the direction of substantial compliance the facility must monitor all three elements that this provision item addresses: 1. The timelines for completion of scheduled assessments 2. The appropriateness of interval assessments in response to changes in status 3. The quality of all assessments (compliance with accepted standards of practice).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The medical director reported that medical and psychiatric diagnoses were formulated in accordance with ICD/DSM nomenclature. Per the self-assessment, a random audit of 10 psychiatry clinic notes showed 100% compliance with DSM nomenclature. Audits of active records indicated that diagnoses conformed to ICD nomenclature, but the audits continued to lack evidence that the diagnoses aligned with the presentation of the individuals and the signs and symptoms of the disease. The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature and the diagnoses fit the signs, symptoms, and presentation of the individuals. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance.	Substantial compliance

#	Provision	Assessment of Status	Compliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The self-assessment reported that assessment of this provision involved review of individuals with self-injurious head banging behavior and aspiration pneumonia. Moreover, a system was in place to monitor these individuals on a quarterly basis. The H1 state draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as appropriate. Additionally, the draft guidelines stated that the facility was responsible for providing education and development of the clinical staff with regards to the guidelines and protocols. It would appear that monitoring would need to be more frequently conducted. Determining compliance with a given protocol will require that a measurable standard or metric – clinical indicators – be developed. The minimum common elements of clinical care could be applied to many conditions, such as constipation or pneumonia. Medical, nursing, physical therapy, and dietary all contribute to the planning and treatment for individuals diagnosed with these conditions. Clinical indicators are helpful in objectively determining if treatments and interventions are timely and clinically appropriate. They also provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the facility must monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The facility will need to develop protocols and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Many existing data sets have the potential to provide insight on how prioritization should occur. Medical audits, hospital and emergency department data, as well as the sick call roster, may all provide information on what conditions are most important to address.	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The medical director reported that a new worksheet with aspiration pneumonia guidelines was developed an incorporated into the Pneumonia Review Committee in April 2014. It was also used in the weekly PNMT meetings. Follow-up occurred in the Clinical CQI meetings. The proposed section H guidelines stated that the facility would ensure that identified clinical indicators measure the response to treatment and interventions and data would be monitored to determine the appropriateness of the interventions. The actions steps	Noncompliance

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		to achieve this centered on development of clinical indicators by the clinical disciplines for seven acute and chronic health care conditions. The facility had established a list of clinical indicators that were reviewed through the Continuous Medical Quality Committee, however, this list did not include indicators for all clinical disciplines. The development of indicators for the seven conditions, proposed by the state, was a good starting point. As discussed in section H3, additional indicators are needed. Once guidelines are established and indicators are identified, the facility will have a more objective means of assessing treatment. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Continue the ongoing efforts related to development of clinical indicators 2. Ensure that the data reported is thoroughly reviewed and analyzed	
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.	The facility assessed compliance with this provision by looking at ISP attendance and completion of the Preventive Care Flowsheets. The self- assessment noted that a new electronic Preventive Care Flowsheet was in development that would be completed around the time of the annual ISP. The proposed section H guidelines indicated that the health status was discussed in the annual ISP and ISPAs as identified by the IDT and a plan was developed to address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team noted that the participation of the medical providers in the annual ISPs increased, but improvement was still needed and participation in ISPAs was largely limited to two providers. The facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both <u>acute changes and chronic long-term disease</u>. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy) • Acute assessments via sick call • Reports of acute changes via the daily clinical meetings and other status change	Noncompliance

#	Provision	Assessment of Status	Compliance
		meetings • ISPA Process • Medical databases (preventive care, cancer screenings, seizure management) • A medical quality program would be the designated quality program and would report certain data elements to the QA/QI council With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team identified a number of concerns related to current processes and systems: • There were multiple deficiencies identified related to the provision of preventive care services. The facility did not have adequate systems to track preventive care and record reviews indicated poor compliance with requirements for several cancer screenings. • Documentation of interval assessments by primary providers was poor. • Risk identification and mitigation continued to present challenges for most disciplines. Medical assessments did not include any documentation of risk assessment. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The effective monitoring of health status requires proper oversight of risk assessment and provision of medical care. This will require a robust medical quality program. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Improve the provision of preventive care and tracking of preventive care 2. Resolve issues related to data collection and data integrity 3. Ensure risk is appropriately addressed by primary medical providers 4. Address attendance at ISPs and ISPAs	
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.	Guidelines were developed for the management of hypertension and hyperlipidemia. According to the medical director, audits were being completed to determine if treatments and interventions were being appropriately modified based on the clinical guidelines. The facility must identify clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on existing clinical	Noncompliance

#	Provision	Assessment of Status	Compliance
		guidelines. These indicators will help determine when treatment plans must be altered. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and intervention. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of 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 implemented a local policy on 9/5/13. The self-assessment reported that training occurred on 3/20/14. State office had yet to develop a finalized policy to ensure that the provisions of sections G and H were moving in the right direction. In many instances, the actions of the facility were not consistent with the draft guidelines for section H that the monitoring team was provided by state office. Achieving substantial compliance will require that the facility have policies and procedures that are congruent with a finalized state policy. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facilities self-rating of substantial compliance. To move in the direction of substantial compliance, a state policy related to Provision H should be developed. SASSLC will need to revise its local policy once a state policy is issued.	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:** <u>Documents Reviewed</u>: ○ DADS Policy #006.1: At Risk Individuals dated 12/29/10 ○ DADS SSLC Risk Guidelines dated 4/17/12 ○ List of individuals seen in the ER in the past year ○ List of individuals hospitalized in the past year ○ List of individuals with serious injuries in the past year ○ List of individual at risk for aspiration ○ List of individuals with pneumonia incidents in the past 12 months ○ List of individuals at risk for respiratory issues ○ List of individuals with contractures ○ List of individuals with GERD ○ List of individuals at risk for choking ○ Individuals with a diagnosis of dysphagia ○ List of individuals at risk for falls ○ List of individuals at risk for weight issues ○ List of individuals at risk for skin breakdown ○ List of individuals at risk for constipation ○ List of individuals with a pica diagnosis ○ List of individuals at risk for seizures ○ List of individuals at risk for osteoporosis ○ List of individuals at risk for dehydration ○ List of individuals who are non-ambulatory ○ List of individual who need mealtime assistance ○ List of individuals at risk for dental issues ○ List of individuals who received enteral feeding ○ List of individuals with chronic and acute pain ○ List of individuals with challenging behaviors ○ List of individuals with metabolic syndrome ○ List of individuals who were missing and/or absent without leave ○ List of individuals required to have one-to-one staffing levels ○ List of 10 individuals with the most injuries since the last review ○ List of 10 individuals causing the most injuries to peers for the past six months ○ Data summary report on assessments submitted prior to annual ISP meetings ○ Data summary report on team member participation at annual meetings. ○ A list of all individuals at the facility with the most recent ISP meeting date and date ISP was filed. ○ Draft ISPs and Assessments for Individual #337 and Individual #90

	○ ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #128, Individual #116, Individual #349, Individual #279, Individual #313, Individual #119, Individual #194, Individual #287, Individual #95, Individual #285, Individual #313, Individual #47, and Individual #325. <u>Interviews and Meetings Held</u>: ○ Informal interviews with various individuals, direct support professionals, program supervisors, and QIDPs in homes and day programs; ○ Charlotte Fisher, Director of Behavioral Health Services ○ Adrianne Berry, Incident Management Coordinator ○ Rhonda Sloan, QIDP Coordinator ○ Joan O'Connor, Assistant Director of Programming <u>Observations Conducted</u>: ○ Observations at residences and day programs ○ Incident Management Review Team Meeting 4/28/14 and 4/29/14 ○ Morning Unit Meeting 5/1/14 ○ Morning Clinical Meeting 4/28/14 ○ QA/QI Meeting 4/29/14 ○ ISP preparation meeting for Individual #255 and Individual #12 ○ Annual IDT Meeting for Individual #337, Individual #90, and Individual #149.
	Facility Self-Assessment: SASSLC submitted its self-assessment updated 4/17/14. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. To assess compliance, the facility: • Completed one section I monitoring tool per month between September 2013 and February 2014. • Reviewed IRRFs completed during the same time period. • Reviewed data collected by the facility on implementation of risk action plans. Each provision included a general statement reflecting an acknowledgement that more work needed to be done for each provision before compliance was met. It was not evident that the facility had an adequate self-assessment process in place to review the risk process.

	The facility self-rated each of the three provision items in section I in noncompliance. While the monitoring team agreed with the facility's findings for noncompliance, it will be necessary for the facility to develop an adequate assessment process to identify areas for focus in order to move forward.
	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. The facility was in the process of retraining QIDPs and IDTs on completing the risk identification process. A large turnover in the QIDP department had necessitated new training on the risk process. The parties agreed that the monitoring team would conduct reduced monitoring for I1, I2, and I3 because the facility had made little progress. The facility was not in compliance with the three provisions. The monitoring team observed the risk identification process at two ISP meetings and noted progress. Notably, each discipline presented relevant information during the risk determination process that was essential for determining risk in each area identified by the IRRF. Both teams engaged in integrated discussion regarding the identification of risks. Teams were doing a much better job of discussing risks in relation to preferences and other support needs. The facility continued to struggle, however, with ensuring that all assessments were completed and available for review prior to annual ISP meetings. Without up-to-date assessment information, it was unlikely that accurate risk ratings could be assigned during annual IDT meetings. As noted in section F, the facility did not have an adequate system in place to monitor supports. Teams were not consistently documenting the completion of assessments. Resulting recommendations and supports were not monitored to ensure consistent implementation. This was particularly alarming considering the high incidence of deaths, injuries, and illnesses at the facility. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Provision I3 requires evidence that plans were implemented in a timely manner once risks were identified. The facility reported that, due to the turnover in the QIDP department, ISPs were often not filed and available for implementation within 30 days of development. Furthermore, the monitoring found that IHCPs were not being filed with the corresponding ISP, so direct support staff did not have access to plans developed by the team to address risks. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • A strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation. • Plans should be implemented immediately when individuals are at risk for harm, and then

	monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The parties agreed that the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. The state policy, At Risk Individuals 006.1, required IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop an integrated health care plan (IHCP) to address risk at that time. The determination of risk was expected to be a multi-disciplinary activity that would lead to referrals to the PNMT and/or the behavior support committee when appropriate. IHCPs were designed to provide a comprehensive plan to be completed annually and updated as needed. The monitoring team observed two annual ISP meetings. Progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). At the IDT meetings observed, each discipline presented relevant information during the risk determination process. Both teams engaged in integrated discussion regarding the identification of risks. The ISP facilitator at both meetings played a much more active role in leading the discussion and ensuring that risks were discussed in relation to preferences and priorities for training. Discussion regarding risks was interwoven into the ISP process. This was very positive to see. The state policy required that all relevant assessments be submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. The facility was gathering data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of discipline specific assessments for September 2013 through February 2014 indicated that there were improvements in the number of assessments submitted prior to ISP planning meetings for seven of 12 disciplines. The chart below shows assessment submission rates for that time period. Discipline Clinical 44% Functional Skills Assessment 33% Dental 99% Dietary 86% OT/PT 92%	Noncompliance

#	Provision	Assessment of Status	Compliance

Communication	81%
Audiology	44%
Nursing	79%
Pharmacy	98%
Behavioral Health	45%
Psychiatry	23%
Day Programming/Vocational	56%

A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP. The pre-ISP determination of assessments needed prior to the annual IDT meeting list was compared to assessments submitted for six individuals. The sample was Individual #128, Individual #116, Individual #349, Individual #279, Individual #313, and Individual #325. Zero (0%) of six individuals had all assessments recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks.

It will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.

Though there had been some improvements in using assessment results to assign risk ratings, it was not yet evident that all individuals had accurate risk ratings determined by assessment results. For example,

- Individual #47's IRRF indicated that she was at medium risk for fractures even though she was at high risk for falls and had sustained 33 injuries over the past six months. Similarly, she was rated as medium risk for seizures. She had active seizures, was prescribed two anticonvulsants, and her ISP noted that she wore a helmet to prevent head injury during seizures. Her IRRF was last updated 5/2/13. She did not have an IHCP in place.
- Individual #313's IRRF indicated that he was at medium risk for gastrointestinal issues. Given his history of gastrointestinal related issues, he should have been considered high risk. His history included GERD, hiatal hernia, chronic gastritis, and numerous episodes of emesis over the past 12 months. The frequency of his emesis placed him at high risk for aspiration. Given his history of frequent hospitalizations, his supports did not appear to be effective.

In order to mitigate risk prior to a significant event or change in status, IDTs should carefully consider all risk indicators and conservatively assign risk ratings with the intent of implementing supports to minimize risks before an adverse outcome or change in status occurs.

#	Provision	Assessment of Status	Compliance
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The parties agreed that the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. Health risk ratings will need to be consistently implemented, monitored, and revised when significant changes in individuals' health status and needs occurred. As noted in section F, data were often not consistently reviewed. This raised the question of whether IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. For example, • Individual #349's IHCP indicated that the IDT would request a consult with dental staff regarding infection and with his PCP regarding constipation. There was no documentation showing that either consultation had been obtained, or if obtained, that recommendations were implemented. • Individual #142's IHCP indicated that the team had recommended a dietary consultation to address his weight. There was no evidence that the consultation was obtained. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. The facility did not yet have an adequate system in place to ensure that all recommended assessments were completed in a timely manner.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions	The parties agreed that the monitoring team would conduct reduced monitoring for this subsection because the facility had made limited progress. The noncompliance finding from the last review stands. The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner, if indicated by the risk status. According to data provided to the monitoring team, plans were still not in place to address risks for all individuals designated as high or medium risk in specific areas. The	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>following data details the percentage of individuals with plans in place for specific risk categories.

<table>
<tr><th>Risk Category</th><th>% of Individuals at High Risk with Risk Action Plans</th><th>% of Individuals at Medium Risk with Risk Action Plans</th></tr>
<tr><td>Seizures</td><td>90%</td><td>75%</td></tr>
<tr><td>Dehydration</td><td>57%</td><td>82%</td></tr>
<tr><td>Aspiration</td><td>89%</td><td>80%</td></tr>
<tr><td>Weight Loss</td><td>89%</td><td>68%</td></tr>
<tr><td>Diabetes</td><td>No data</td><td>No data</td></tr>
<tr><td>Chronic Resp.</td><td>91%</td><td>78%</td></tr>
<tr><td>Constipation</td><td>100%</td><td>80%</td></tr>
<tr><td>Skin Breakdown</td><td>86%</td><td>79%</td></tr>
<tr><td>Dental</td><td>92%</td><td>81%</td></tr>
<tr><td>Osteoporosis</td><td>84%</td><td>82%</td></tr>
<tr><td>Falls</td><td>86%</td><td>71%</td></tr>
<tr><td>GERD</td><td>89%</td><td>72%</td></tr>
<tr><td>Choking</td><td>100%</td><td>77%</td></tr>
</table>

Although the percentage of individuals with plans to address risks had improved in most areas, the facility reported that, for annual ISP meetings held between 9/1/13 and 2/28/14, only 44 of 108 (41%) of the ISPs were filed within 30 days of development. Thus, support plans to address risks identified at the annual ISP meeting were not available to staff designated to implement the plan. Furthermore, a sample was reviewed onsite and the monitoring team found that none of the ISPs filed in individual notebooks included the IHCP. DSPs need to have access to and be trained on support strategies in the IHCP.

The state policy required that the follow-up, monitoring frequency, clinical indicators, and responsible staff will be established by the IDT in response to risk categories identified by the team. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed. Thus, even with plans in place, individuals remained at risks for negative outcomes.

It was not evident that plans to address risks were consistently monitored for implementation or efficacy. For example,
• DFPS case #42938656 involved a confirmed allegation of neglect against the facility for failure to follow Individual #108's PNMP which addressed his high</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		risk for fractures. Staff involved in the incident reported that they were never trained on his plan. • DFPS case ##43018646 also involved a confirmed allegation of neglect when Individual #75 sustained a serious injury during bathing. Staff involved in the incident were not implementing his plan to address his risk for fractures. The investigation included a recommendation to train all residential staff at the home involved on use of bathing equipment. Documentation indicated that training was not completed until three weeks after the incident. All staff should have been trained immediately to prevent similar incidents from occurring. • Individual #47 had a plan in place to address her high risk for falls and injury. She sustained a serious injury on 4/20/14. A preliminary investigation indicated that staff were not following her risk action plan. Her QIDP had not completed a monthly review of supports and services in the past six months to ensure that supports were being implemented and were effective. • Individual #313 was hospitalized "multiple times over the past year" according to an ISPA dated 2/7/14. He was considered high risk for aspiration and respiratory compromise. His IDT met 2/7/14 to update supports. The ISPA indicated that the IDT would reconvene in 30 days to review supports. There was no indication that the team met again. His QIDP had not completed monthly reviews over the past six months. Many of the risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an ancillary plan in place or instructions were too general (e.g., follow-up with PCP, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: 1. Develop action plans with measurable criteria for assessing outcomes. 2. Ensure that staff designated to implement plans have access to those plans. 3. Document the implementation of action plans. 4. Document that clinical data is gathered and reviewed at least monthly. 5. Document action taken to revise supports when data indicates that current supports are not effective.	

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

	completed o Spreadsheet of all individuals (both new admissions and existing residents) who had a REISS screen completed in the previous 12 months o For four individuals enrolled in psychiatric clinic who were most recently admitted to the facility: Information Sheet; Consent Section for psychotropic medication; ISP, and ISP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive Psychiatric Evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated Progress Notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refused to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attended or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the IDT, ISP, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that related to the role of psychiatrists o A list of all psychiatrists including board status; with indication who was designated as the facility's lead psychiatrist o CVs of all psychiatrists who worked in psychiatry, including any special training such as forensics, disabilities, etc. o Description of administrative support offered to the psychiatrists o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 <u>newly prescribed</u> psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses were revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who had a psychiatric assessment per Appendix B, with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission

	○ Appendix B style evaluations for the following 10 individuals: • Individual #261, Individual #138, Individual #4, Individual #305, Individual #17, Individual #142, Individual #204, Individual #290, Individual #106, and Individual #174 ○ Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings ○ A list of individuals requiring chemical restraint and/or protective supports in the last six months ○ Section J presentation book <u>Documents requested onsite:</u> ○ Facility specific psychiatry services policy. ○ List of individuals meeting criteria for polypharmacy who have been reviewed by polypharmacy committee. ○ Documentation resulting from ISP dated 4/30/14 regarding Individual #337. ○ All data submitted, progress notes and doctors orders from psychiatry clinic 4/28/14 regarding Individual #93, Individual #171, Individual #104, Individual #120, and Individual #249. ○ Data regarding the number of individuals in psychiatry clinic who meet criteria for polypharmacy. ○ Tracking data for psychiatry attendance at ISP meetings vs. the number of meetings held. ○ Tracking data for psychiatry IIRF submission for the last six months. ○ Five examples of psychiatry IIRF submissions. ○ Minutes from the MOSES/DISCUS work group meeting for the previous six months. ○ All data submitted, doctor's orders and progress notes from emergency psychiatry clinic 4/30/14 regarding Individual #255. ○ Copy of neurology/epileptology clinical information book. ○ Psychiatry support plans for Individual #264 and Individual #299. ○ These documents: ○ Demographic Data Sheet ○ Consent Section (last six months) ○ Individual Support Plan, ISPAs, and signature sheets (last six months) ○ Social History (most current) ○ Positive Behavior Support Plan and addendums ○ Psychological Evaluation and update ○ Human Rights Committee review of consent for psychotropic medication, pretreatment sedation, and BSP (most current) for the last six months ○ Restraint Checklists for the past six months ○ Suicide Risk Assessment for the last six months ○ Pretreatment Sedation Assessment-most current ○ Annual Physician's Summary, Evaluation, Physical Exam ○ Quarterly Medical Review ○ Active Medical Problem List ○ Hospital section for the previous six months ○ Electrocardiogram, laboratory, and X-ray results for the previous six months ○ Comprehensive Psychiatric Evaluation ○ Psychiatry clinic notes for the previous six months

	○ MOSES/DISCUS examinations for the previous six months ○ Pharmacy Quarterly Drug Regimen Review for the previous six months ○ Consult section/Neurology Consults for the past year ○ Pharmacy Annual Evaluation ○ Physician's orders for the previous six months ○ Comprehensive Annual (most current) ○ Quarterly Nursing Assessment (most current) ○ Integrated progress notes for the previous six months ○ Annual weight graph ○ Seizure graph/Record (Active) last six months ○ Vital Sign Records for the past six months ○ Health Management Plan (most current) ○ Current list of all medications (MAR) ○ Safety Plan/Crises Plan ○ For the following individuals: • Individual #183, Individual #214, Individual #154, Individual #315, Individual #248, Individual #255, Individual #310, Individual #277, and Individual #264 <u>Interviews and Meetings Held</u>: ○ David V. Espino, M.D., Medical Director ○ Sharon M. Tramonte, Pharm. D., Lead Pharmacist ○ Charlotte Fisher, M.A., LPC-S, BCBA, Director of Behavioral Health Services ○ Sergio H. Luna, M.D., facility psychiatrist; Samantha Denise Duran, R.N, psychiatric nurse; and Teresa Ann Valdez, psychiatry assistant ○ Sergio H. Luna, M.D. <u>Observations Conducted</u>: ○ Psychiatry clinic 4/28/14 regarding Individual #93, Individual #171, Individual #104, Individual #120, and Individual #249. ○ Emergency psychiatry clinic 4/30/14 regarding Individual #255. ○ ISP dated 4/30/14 regarding Individual #337 ○ Morning Medical Meeting ○ Pharmacy and Therapeutics Committee ○ Dental Desensitization Committee ○ Polypharmacy Oversight Committee (POC) meeting ○ Medical Staff Meeting ○ Observation of individuals in various homes throughout visit
	Facility Self-Assessment: SASSLC continued to use the self-assessment format it developed for the last review. The facility rated itself as being in substantial compliance with three provisions: J1, J2, and J12. The monitoring team agreed

	with two of these J1 and J12. The psychiatry department included a list of the results of the self-assessment. Further, they were numbered and each result had a corresponding item of the activities engaged in to conduct the self-assessment. In that regard, the psychiatry department attempted to identify activities and outcomes. The facility described the activities engaged in to conduct the review of a particular provision item, the results and findings from these activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The psychiatry clinic staff provided the majority of the update for section J to the monitoring team because of the ongoing vacancy in the position of facility lead psychiatrist. In the comments/status section of each item of the provision, there was a summary of the results of the self-assessment and the self-rating. The monitoring team's review was based on observation, staff interview, and document review. In discussions with the psychiatry department, the need for improved integration with other disciplines was noted. Most provision items in this section rely on collaboration with other disciplines. The facility would benefit from the eventual development of a self-monitoring tool that mirrors the content of the monitoring team's review for each provision item of section J, that is, topics that the monitoring team commented upon, suggestions, and recommendations made within the narrative in order for the facility to reach the goals and requirements to move in the direction of substantial compliance. Even though work is needed, the monitoring team wants to acknowledge the efforts of the psychiatry department in the absence of a lead psychiatrist. The monitoring team did not agree with the facility self-assessment regarding J2. This provision was rated in substantial compliance during the previous monitoring period. At that time, it was noted that the facility psychiatric staff needed to continue their current level of documentation and attend to the number of Appendix B comprehensive assessments that were outstanding in order to maintain this rating for the next monitoring period. While documentation quality was consistent, the facility had only managed to complete an additional 14 Comprehensive Psychiatric Evaluations in six months. Given that 54% of individuals currently participating in psychiatry clinic did not have a current CPE, this provision was rated in noncompliance, in disagreement with the facility self-assessment.
	Summary of Monitor's Assessment: SASSLC was found to be in substantial compliance with two provisions in this section. Since the last monitoring visit, there had been challenges due to a turnover in psychiatric clinic staff. The facility lead psychiatrist position remained vacant and one full time psychiatrist and temporary locum tenens providers were providing services. Currently, 65% of the facility population (154 individuals) was receiving services via psychiatry clinic.

	The monitoring team observed two psychiatric clinics. Per interviews with psychiatrists and behavioral health staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, behavioral health, nursing, QIDP, direct care staff, and the individual). During both clinics, there were reports that some individuals were experiencing increased behavioral challenges. These were opportunities for psychiatry and behavioral health to work together to develop non-pharmacological interventions for specific individuals, but the IDT did not concentrate on this during the clinics observed or in the documentation reviewed. It was time to expand this vital area of clinical intervention to include identification and implementation of non-pharmacological regimens that would be beneficial to the individual instead of a generic plan. The monitoring team similarly identified paucity of combined assessment and case formulation as only 46% of comprehensive psychiatric evaluations per Appendix B had been completed. Further effort must be made regarding determination of the extent of pretreatment sedation for medical procedures, to develop a clinical consultation process for this similar to that utilized for dental clinic. The attention of the IDT was necessary to implement interdisciplinary coordination for individuals who required pretreatment sedations for procedures, for appropriateness of desensitization plan, without restriction on the receipt of necessary dental and/or medical intervention. Plans must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual. The Appendix B evaluations were generally of adequate quality, although the small percentage completed resulted in this provision item being rated in noncompliance. The completion of a Comprehensive Psychiatric Evaluation may actually be utilized in lieu of a quarterly evaluation if completed during the time frame of when the quarterly is due, as long as the necessary elements capture the up to date data. The prior lead psychiatrist at SASSLC determined that at least one more FTE was necessary, particularly to address the completion of the comprehensive assessments and to enhance the attendance of psychiatrists in the ISP meetings. Due to the lack of sufficient psychiatric resources (as summarized by the facility) to ensure the provision of services necessary, provision J5 remained in noncompliance. The paucity of psychiatric resources was also reportedly the determining factor in other areas, specifically related to completion of comprehensive psychiatric evaluations (J6) and the implementation of informed consent practices via the prescribing practitioner (J14). During this monitoring period, the facility had made changes to the manner in which additional medications (i.e., chemical restraints) were categorized. The facility reported a total of three chemical restraints during this monitoring period. There were an additional 16 medication administrations that were categorized as PEMA (psychiatric emergency medication administration). Given this change in category, these administrations were not subjected to post emergency restraint review processes. There was currently no policy and procedure in effect to define this practice or to outline the procedures that must be followed.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications and Experience The psychiatrists providing services at the facility were either board eligible or board certified in psychiatry by the American Board of Psychiatry and Neurology. One provider, board certified in general psychiatry, was also board eligible in Child and Adolescent psychiatry. He had numerous years of experience providing assessment and treatment for individuals with developmental disabilities and had previously provided services at another SSLC. He was employed at SASSLC since 4/16/12. Since the last visit, there remained a vacancy in the position of lead psychiatrist. There were two contracted locum tenens psychiatrist who provided services during this monitoring period. One of these providers was board certified in general psychiatry and board eligible in child and adolescent psychiatry. The other provider was board eligible in general psychiatry. Both providers had approximately two years experience in the treatment of individuals with developmental disabilities. Monitoring Team's Compliance Rating Based on the qualifications of the current psychiatric staff, this item was rated in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs will be reviewed in section J5.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At SASSLC, 154 of the 235 individuals (65%) received psychopharmacologic intervention at the time of this onsite review. The limited psychiatric resources (addressed in J5) was one of the factors resulting in the insufficient number of completed Appendix B evaluations (discussed in J6). Evaluation and Diagnosis Procedures The monitoring team observed one regularly scheduled and one emergency psychiatry clinic. It was apparent that the team members attending the clinic were well meaning and interested in the treatment of the individual. The quarterly psychiatric evaluations were well organized; there was also good discussion and documentation of the individual's history and presenting symptoms. The reviews observed during the visit were not geared toward a revision of diagnostic criteria and identification of the specific indications for the psychotropic medications. This would have been challenging, however, due to the lack of identification of specific target symptoms for monitoring response to prescribed medications. Clinical Justification	Noncompliance

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		The facility self-assessment noted there were 71 of 71 (100%) Quarterly Clinic Addendum-Treatment Plan Reviews done during 9/1/13 to 2/28/13 and that all were documented by the facility as being performed in a clinically justifiable manner with a rationale for the prescription of psychotropic medications. These data were confusing because 154 individuals participated in psychiatry clinic. As such, for there to be 100% compliance with quarterly clinic reviews, 154 reviews would have to be performed. Per a review of 13 records, there was evidence of appropriate clinical documentation, but there was a need to further differentiate psychiatric target symptoms from other maladaptive behaviors, such as self-injurious behaviors and/or aggression that were not necessarily associated with the assigned DSM-IV diagnosis. <u>Tracking Diagnoses and Updates</u> The facility maintained a spreadsheet that indicated changes in Axis I diagnoses. The sheet noted the previous diagnosis, the new diagnosis, and a brief justification for the change in diagnosis. There were concerns regarding these data: of the 12 diagnosis changes, three justifications said the previous diagnosis "does not make sense." <u>Monitoring Team's Compliance Rating</u> This provision was rated in substantial compliance during the previous monitoring period. At that time, it was noted that the facility psychiatric staff needed to continue their current level of documentation and attend to the number of Appendix B comprehensive assessments that were outstanding in order to maintain this rating for the next monitoring period. While documentation quality was consistent, the facility had only managed to complete an additional 14 Comprehensive Psychiatric Evaluations in six months. The completion of a Comprehensive Psychiatric Evaluation may actually be utilized in lieu of a quarterly evaluation if completed during the time frame when the quarterly was due as long as it captures up to date data. This should facilitate further completion of these critical assessments. As discussed in J6, the completion of these assessments was likely hampered by a lack of sufficient psychiatric resources and turnover in providers. Given that 54% of individuals currently participating in psychiatry clinic do not have a current CPE, this provision was rated in noncompliance, in disagreement with the facility self-assessment.	
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,	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a treatment plan or in the absence of a diagnosis. Per the review of 13 records, all had a psychiatric diagnosis noted in the record. Per this provision, individuals prescribed psychotropic medication must have an active treatment program. In all records reviewed, individuals prescribed medication did have a	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.	treatment program on file. The quality of the content of the PBSP documentation is addressed in section K of this report. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. Behavioral health representatives and other staff disciplines were present in psychiatric clinics observed throughout the visit. Given the documentation reviewed and observations of psychiatry clinic performed during the course of this monitoring period, there were collaborative efforts with regard to the pharmacological interventions. As discussed in J2 above, observations did not include reviews of specific diagnoses, however, documentation in the "Quarterly Clinic Addendum-Treatment Plan Review" did review the documented diagnoses. An expansion of this review should include a routine review of non-pharmacological interventions, either occurring or proposed. It will be important for ongoing collaboration to occur between behavioral health and psychiatry to formulate a cohesive case formulation, and in the joint determination of psychiatric target symptoms and descriptors or definitions of the target symptoms associated with the assigned DSM-IV diagnosis, inclusive of behavioral data, and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and that this information is documented in the individual's record in a timely manner. During this monitoring review, issues related to data were noted. It was noted that in many cases, the behaviors tracked via behavioral health did not relate to the determined diagnosis, again, making response to prescribed medication impossible to determine. Per interviews with facility staff, the facility had begun to implement the psychiatric support plan (PSP), which would allow for the determination of target symptoms for monitoring response to psychotropic medication. <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression/SIB (i.e., chemical restraint) had remained stable. During the prior monitoring period, there were five incidents involving three different individuals. During this monitoring period, there were three incidents involving two individuals. A review of the documentation provided by the facility revealed that in all three of the instances, a psychiatrist's progress note regarding the incident was <u>not</u> included. Data regarding the extent of the use of chemical restraint may be misleading. In the intervening period since the previous monitoring review, the facility had begun to categorize the administration of additional psychotropic medication as "Psychotropic Emergency Medication Administration" (PEMA). There was no policy and procedure outlining this designation, and the use of these medications did not result in post restraint monitoring or review. From September 2013 through April 2014 there were 16 administrations of PEMA for eight individuals. Of these administrations, seven were	

#	Provision	Assessment of Status	Compliance
		intramuscular injections. Of these, Individual #214 received four separate administrations of Zyprexa 10 mg on 11/24/13 for a total of Zyprexa 40 mg. This dosage is over the FDA recommended daily dosage limit of 30 mg. During previous monitoring reviews, the simultaneous use of multiple psychotropic medications as a chemical restraint was discussed. Currently, for the three chemical restraints reported, only single agents were utilized. A review of PEMA data, on the other hand, revealed four instances where two medications were utilized. A more parsimonious approach to chemical restraint would be preferable, especially in light of the potential for negative side effects with medication polypharmacy. In situations where the psychiatrist opines that chemical restraint is necessary, particularly involving multiple agents at one time, it must be justified via clinical documentation whether the medication is classified as a chemical restraint or as PEMA. <u>Monitoring Team's Compliance Rating</u> The facility self-rated this item in noncompliance due to inconsistent integration between psychiatry and behavioral health regarding treatment planning, nonpharmacological interventions, and behavior support planning. They did note progress with regard to the reduction in the utilization of multi-agent chemical restraints for those administrations classified as chemical restraints. Given the discussion noted above, the monitoring team was in agreement with the facility self-assessment and this provision remained in noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Extent of Pretreatment Sedation</u> There were two lists of individuals who received pretreatment sedation for either medical or dental clinic. The facility provided data in one comprehensive list of individuals who received pretreatment sedation medication <u>or</u> TIVA for dental procedures that included: individual's name, designation indicating dental pretreatment sedation, date the sedation was administered, name, dosage, and route of the medication, the date of the IDT review to minimize the need for the use of the medication, an indication of whether or not the individual was participating in psychiatry clinic, and an indication of whether or not the individual had a desensitization plan. A second listing of individuals who received pretreatment sedation for medical procedures was provided that included: the date the sedation was administered, the individual's name, the medication, dosage, and route of the medication, the name of the physician who ordered the medication, and the indication. The dental listing from September 2013 through February 2014 indicated there were 66 instances of pretreatment sedation for dental clinic. The summary also included when TIVA was administered (TIVA is reviewed in section Q). Of the 66 administrations of pretreatment sedation, 43 were TIVA. Of all 66 administrations, 47 were for individuals currently participating in psychiatry clinic who	Noncompliance

#	Provision	Assessment of Status	Compliance
		were also administered a daily regimen of psychotropic medication and, therefore, were at risk for potential drug-drug interactions. Data regarding individuals receiving pretreatment sedation for medical procedures indicated that between September 2013 and April 2014, there were seven administrations. Of these, three were for Individual #310. This individual was administered intramuscular Ativan 2 mg, intramuscular Benadryl 50 mg, and oral Benadryl 50 mg on 11/13/13. Individual #310 was also prescribed psychotropic medications, including Clomipramine, Cymbalta, Deplin, Ativan, and Seroquel. Two administrations were for Individual #178. This individual was administered Haldol 5 mg and Ativan 2 mg orally. Individual #178 was also prescribed Tegretol, Carbamazepine, and Klonopin. Given the number of medications each of these individuals was prescribed, the addition of two agents for pretreatment sedation was concerning due to the potential for drug-drug interactions. In the previous monitoring report, concerns regarding individuals receiving multiple pretreatment sedations were documented. Data reviewed for this monitoring period did not reveal individuals receiving numerous pretreatment sedations, however, as noted above, there were two individuals who received two or more agents for the purposes of one pretreatment sedation for a medical procedure. For dental clinic, there were four individuals who received sedation twice during this period. All of these individuals were participating in psychiatry clinic. <u>Interdisciplinary Coordination</u> There were 10 examples provided of multidisciplinary consultation regarding the utilization of pretreatment sedation for individuals in dental clinic. Unfortunately, there were no examples provided for pretreatment sedation for individuals requiring medical procedures. Nine of the 10, however, were dated prior to this monitoring period. The 10 examples provided revealed consultative recommendations from primary care, psychiatry, and pharmacy. Give the information on the form, it was not possible to determine what the consensus recommendation was. Per staff report, the consensus recommendation was obtained during a review of the consultation during the morning medical meeting. This was not observed during this monitoring visit because there were no pending consultations during this time. <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. Information provided indicated that there were no currently implemented desensitization plans. This was echoed by the facility self-assessment, which indicated that none of 163 individuals (0%) receiving psychiatric services who required pretreatment sedation had a pending desensitization plan	

#	Provision	Assessment of Status	Compliance
		implemented within the past six months. Discussions with facility staff indicated that there had been some progress with regard to assessment of individuals who required pretreatment sedation. A dental desensitization committee had been convened and met monthly. This group had created a listing of individuals who required pretreatment sedation indicating where each individual was in the assessment process, had developed a routine general assessment process modeled after one utilized at Lufkin SSLC, and were planning to develop an appointment preference assessment to assist with adherence. The monitoring team discussed with facility staff concerns regarding the lack of policy and procedure governing pretreatment sedation processes. The development of this document would help formalize the process and delineating responsibilities for staff. The monitoring team discussed with facility staff that what was first necessary was a process to triage those individuals who would be immediately amenable to desensitization, and then an individualized assessment of the individual's abilities and where that individual could start desensitization, on a continuum. For example, some individuals may be able to come to dental clinic and sit in the dental chair. Others may be able to start with basic dental hygiene activities. The facility should understand that the goal of this provision is that there be treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals, though certainly will be necessary for some individuals. <u>Monitoring After Pretreatment Sedation</u> A review of documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs. There had also been an expansion of monitoring due to the implementation of regular TIVA clinics. A nurse was assigned to the dental clinic to monitor individuals following TIVA. In order for the nurse to be experienced with TIVA, nursing staff and dental clinic staff had identified a staff member to participate regularly. If individuals recovered appropriately from TIVA, they were returned to their home for monitoring by their regular nursing staff. If there were any concerns, the individual would spend the night in a home with 24-hour nursing services (however, see the example presented in sections L and Q). <u>Monitoring Team's Compliance Rating</u> This item remains in noncompliance, in agreement with the facility self-assessment, as further effort must be made regarding the determination of the extent of pretreatment sedation for medical procedures, in the development of a clinical consultation process for	

#	Provision	Assessment of Status	Compliance
		medical pretreatment sedation similar to that utilized for dental clinic, and in regard to documentation of the consensus recommendations. Further, the facility must develop a continuum of individualized interventions from simple strategies to desensitization plans in an effort to reduce their reliance upon pretreatment sedation.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	<u>Psychiatry Staffing</u> Approximately 65% of the census received psychopharmacologic intervention requiring psychiatric services at SASSLC as of 4/28/14. There were two FTE psychiatrists providing services at the time of this monitoring visit, one was an employee, the other provided via a contract with a locum tenens company. The two facility psychiatrists were scheduled to work 40 hours per week and were available after hours via telephone consultation. The current contract physician began work just prior to this monitoring visit. During the monitoring period, two other contract psychiatrists had provided services at the facility. <u>Administrative Support</u> There was a full time psychiatry assistant and a full time psychiatric nurse. These staff, although enthusiastic and energetic, were experiencing difficulties due to the lack of a lead psychiatrist. The facility was reportedly in the process of attempting to recruit a full time psychiatrist for the lead position. <u>Determination of Required FTEs</u> It was questionable whether the current allotment of psychiatric clinical services was sufficient to provide clinical services at the facility. At the time of the review, there were a total of 80 available clinical hours. Currently, one psychiatrist had a caseload of 96 individuals whereas the second, temporary, psychiatrist had a caseload of 58. Caseloads of this level did not allow for time to address completion of the Comprehensive Psychiatric Evaluations or to allow for regular attendance at ISP meetings. SASSLC should engage in an activity to determine the amount of psychiatry service FTEs required. This computation should consider hours for clinical responsibility, obtaining consent for psychotropic medications, documentation of delivered care (i.e., quarterly reviews, Appendix B evaluations), required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, participation in polypharmacy meetings), in addition to improved coordination of psychiatric treatment with neurology, primary care, other medical consultants, pharmacy, and behavioral health. If additional psychiatric resources are not available, the facility could consider midlevel providers (e.g., nurse practitioners). The facility self-assessment included information regarding some of the activities each psychiatric physician participated in over the course of the previous six months. These data did not include parameters, such as time requirements for each activity and/or an analysis	Noncompliance

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		of the data, but did result in a self-rating of noncompliance due to lack of sufficient psychiatric resources needed to provide required services. Monitoring Team's Compliance Rating Due to the lack of necessary psychiatric resources, this provision remained in noncompliance in agreement with the facility self-assessment.	
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.	Appendix B Evaluations Completed For the previous monitoring report, SASSLC psychiatry staff provided a list of 58 comprehensive psychiatric evaluations (CPE) per Appendix B guidelines that were completed as of 8/29/13. In the intervening period since the previous review, an additional 14 CPEs were completed. Given that 154 individuals received treatment via psychiatry clinic, 54% of individuals still required CPE. There was a facility-specific policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 7/1/13. It included a new psychiatry clinic form as well as quarterly addendum notes inclusive of treatment planning regarding the use of psychotropic medications. The comprehensive nature of psychiatry clinical consultation had been expanded to include all facility homes, and per observation and documentation reviewed, this comprehensive clinical process had been maintained. Given the changes in psychiatry clinic required by the policy (e.g., increased number of clinics, longer clinics, need for increased information provided for clinic, increased documentation requirements for all clinic attendees), the implementation had not been without challenges. Appendix B style evaluations were reviewed for the following 10 individuals: Individual #261, Individual #138, Individual #4, Individual #305, Individual #17, Individual #142, Individual #204, Individual #290, Individual #106, and Individual #174. The CPEs performed by the current psychiatric physicians were complete in that they followed the recommended outline and included pertinent information. All of the examples included a five-axis diagnosis and documented a detailed discussion regarding the justification of diagnostics. All Appendix B evaluations reviewed included case conceptualizations and history that reviewed information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation, however, the examples generally did not include any other	Noncompliance

#	Provision	Assessment of Status	Compliance
		nonpharmacological interventions outside of the individual's PBSP. <u>Monitoring Team's Compliance Rating</u> Although the completed evaluations were generally of adequate quality, the small percentage of those completed resulted in this provision remaining in noncompliance, in agreement with the facility self-assessment. Per interviews with the psychiatry clinic staff, there were plans to schedule comprehensive psychiatric evaluations each month. The psychiatrists' duties would require the completion of approximately eight evaluations per month in order to meet substantial compliance with this provision within 11 months.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SASSLC who did not have a current psychiatric assessment. • The facility had four new admissions for the previous six months with all of these individuals being administered a Reiss screen within two weeks of admission. • One individual was admitted in October 2013. The Reiss screen was administered 10/4/13. This individual was not referred to psychiatry clinic for a CPA within the required time frame. The CPA was completed 10 weeks following admission on 12/19/13. • Another individual was admitted to the facility in February 2014. Per the facility self-assessment, this individual had a CPE within 30 days of admission. This individual's record was provided for review, but the CPE was not included. In addition, this individual was not included in the list of completed CPEs. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess due the lack of integration between the psychiatry and behavioral health department in the presentation and comparison of the data. The total facility census was 235 with 154 individuals (65%) enrolled in psychiatry clinic. Therefore, 81 individuals were eligible for baseline Reiss screening. A listing of individuals who had received Reiss Screens included the names of all individuals residing at the facility. There were 76 individuals who had results "consistent with a mentally health individual." Given the data provided, it was difficult to determine which individuals were enrolled in the psychiatry clinic, which were referred and entered the clinic following a routine Reiss Screen, which were screened due to a change in status and then entered the clinic, and which had received a required baseline screening. Regardless, given that all individuals were represented, and there were scores for all individuals (though dates of screenings were not always included), it appeared that baseline screenings had been completed. In addition, data reviewed revealed that in four instances a "repeat" Reiss Screen had been	Noncompliance

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		performed due to change in status. Given the manner of presentation of the data, it was not possible to determine the outcome of the "repeat" Reiss Screen (i.e., if it led to a comprehensive psychiatric evaluation). Referral for Psychiatric Evaluation Following Reiss Screen The referral and response process for psychiatric consultation following Reiss Screening was included in policy and procedure entitled, "SASSLC Psychiatry Clinical Services Policy." The procedure included a requirement for Reiss Screening of all new facility admissions, for a psychiatry clinic within 10 working days of admission for new admissions that have been identified as in need of psychiatric services, and for completion of a comprehensive psychiatric evaluation in Appendix B format within 30 calendar days of admission. The document did not address the use of the screen for change of status, or referral to psychiatry due to a positive screen or a change in status. Monitoring Team's Compliance Rating The facility self-rated this provision in noncompliance and the monitoring team is in agreement. Data presented during this monitoring review were improved in that it appeared that baseline screens had been completed. There were issues in that individuals newly admitted to the facility did not have a completed comprehensive psychiatric evaluation performed within 30 days as required by policy. In addition, there was no allowance for Reiss Screening or psychiatric referral due to change of status in policy. It was not possible to determine the outcome of the four instances where individuals received Reiss Screening due to changes in status (e.g., death of a family member or caregiver, relocation, health issues).	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Policy and Procedure Per the "Psychiatry Services Procedure Manual" dated 5/23/13, "each state center will develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation…annual and quarterly reviews will be conducted with participation of the IDT and the individual (if the individual is able to participate)." The policy then defined the roles of IDT members including nursing, behavioral health, QIDP, DSP, dietary, habilitation therapy, and workshop representatives outlining a system to integrate pharmacological treatment with behavioral and other interventions. The facility had a facility specific policy and procedure regarding psychiatry in effect dated 7/1/13, but this document did not specifically address a system to integrate pharmacological treatments with behavioral and other interventions. However, psychiatry clinics were far more comprehensive than they had been by including staff from various disciplines to ensure appropriate discussion and treatment planning for individuals. This was observed during the current monitoring review. The more comprehensive clinic	Noncompliance

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		process had been fully implemented at the facility. Interdisciplinary Collaboration Efforts The monitoring team observed two separate psychiatric clinics (one scheduled and one emergency). Per interviews with psychiatry and behavioral health staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, behavioral health, nursing, QIDP, direct care staff, and the individual). There were improvements in the quality of data provided by behavioral health. In the regularly scheduled clinic observed during this monitoring visit, data were graphed and up to date. Psychiatry staff interviewed reported concerns regarding the consistency/integrity of data collected. It was noted that data graphs had improved and frequently included timelines or event markers. In addition, it was observed and reported by psychiatry clinic staff that behavioral health staff were making efforts to provide an analysis for data results. Behavioral health staff must improve the description and analysis of the data and their assessment of what the presented data means, so that all members present have a good understanding. While data were documented in the record as the impetus for medication adjustments, both psychiatry and behavioral health staff predominantly discussed maladaptive behavior, such as aggression and self-injurious behavior, but did not focus on the observable psychiatric symptoms that resulted in the assigned psychiatric diagnosis. Medication decisions made during clinic observations conducted during this onsite review were based on approximately 20 minute observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the regularly scheduled psychiatry clinic observation, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. As stated repeatedly in this report, there was an IDT process within the psychiatry clinic with representatives from various disciplines participating in the clinical encounter. While this was a positive development, again, there was a need for improvement in the analyzed data with regard to making adjustments to the individual's psychotropic medication regimen. For the emergency psychiatry clinic, the psychiatrist met with the individual, the nurse case manager, and DSP staff. A formal data presentation was not available due to the emergent nature of the consultation. A review of the behavioral health and psychiatric documentation for 13 individual records revealed case formulations that tied the information regarding a particular individual's case together, documented in the "Quarterly Clinic Addendum-Treatment Plan Review." There was clear documentation of the IDT process in psychiatry clinic as well as the use of	

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		information from other disciplines in the formulation of the individual's diagnosis. What made this process challenging was that, in many cases, the "Quarterly Clinic Addendum-Treatment Plan Review" was the only case formulation available. This was due to the paucity of comprehensive psychiatric evaluations completed per Appendix B. Therefore, there were inconsistencies with regard to the implementation of a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. Case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. There was minimal discussion during the psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and behavioral health in determining the presence of symptoms and in monitoring symptom response to targeted interventions. <u>Integration of Treatment Efforts Between Behavioral Health and Psychiatry</u> The biggest challenges with regard to integration remained as outlined: • The presentation of behavioral data was not helpful in determination of the efficacy of the psychopharmacological regimen. • The deficiency in the completion of the collaborative case formulations for each individual enrolled in psychiatry clinic per Appendix B. • The need for the identification and implementation of non-pharmacological interventions specific to the individual's needs. • The current vacancy in the position of lead psychiatrist. <u>Coordination of Behavioral and Pharmacological Treatments</u> There was cause for concern with regard to some examples of rapid, multiple medication regimen alterations in the absence of data review to determine the effect of a specific medication change on the individual's symptoms or behaviors. The generally accepted professional standard of care is to change medication dosages slowly, one medication at a time, while simultaneously reviewing the data regarding identified target symptoms. In this manner, the psychiatrist can make data driven decisions with regard to medications, and the team can determine the need to increase or alter behavioral supports to address symptoms. This type of treatment coordination was not evident in the psychiatric clinics observed, or in the clinical documentation reviewed. Additionally, documents reviewed revealed a paucity of nonpharmacological interventions outside of the individual's PBSP.	

#	Provision	Assessment of Status	Compliance
		For example, Individual #95 had multiple medication regimen changes over the course of three days 4/8/14 through 4/10/14: • 4/8/14 Haldol 5 mg IM was administered as a single dose. Note: this medication administration was not classified as a chemical restraint, but rather as PEMA (psychiatric emergency medication administration). • 4/9/14 Zyprexa started at 15 mg at bedtime. • 4/9/14 Lorazepam increased to 3 mg three times daily. • 4/10/14 a cross taper of Prozac/Zoloft was initiated. • 4/10/14 Cogentin started at 0.5 mg twice daily. Review of this individual's record revealed target symptoms for the specific medication documented by the psychiatrist. The multiple medication regimens over this brief period of time did not allow for a review of data to determine the individual's response to these regimen changes. In addition, it was documented that Individual #95 had been engaging in aggressive, self-injurious behavior resulting in administration of intramuscular medications. Due to a change in reporting, this was classified as PEMA as opposed to a chemical restraint. For additional discussion regarding this topic, see J3. <u>Monitoring Team's Compliance Rating</u> The monitoring team agreed with the facility self-assessment that this provision remained in noncompliance. The monitoring team identified a paucity of combined assessment and case formulation, a lack of identification of non-pharmacologic treatment interventions outside of the PBSP, and a lack of coordination in behavioral and pharmacological interventions.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other	<u>Psychiatry Participation in PBSP and other IDT activities</u> The prescribing psychiatric practitioners did not routinely attend meetings regarding behavioral support planning for individuals assigned to their caseload, therefore, psychiatry staff were not consistently involved in the development of the plans. The facility self-rated noncompliance due to the continued need for PBSPs to be reviewed in collaboration with the IDT by the psychiatrist. The data provided by the self-assessment indicated that of 10 PBSP documents reviewed by the psychiatrist during this monitoring period, all 10 documented a "discussion of strategies to reduce the use of emergency medications and generate a hypothesis regarding behavioral-pharmacological interventions as evidenced by the prescribing psychiatrists written documentation of the reviewed PBSP." The self-assessment also noted that 30 of 67 (45%) PBSP reviews during psychiatry clinic reflected "IDT member signatures on the corresponding clinic note to indicated collaborative efforts in determining the least intrusive interventions to treat the behavioral or psychiatric condition, and whether the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individual will be best served primarily through behavioral, pharmacology, or other interventions, in combination or alone." These data were confusing because there were 154 individuals participating in psychiatry clinic. Therefore, only 19% of PBSP documents had been reviewed. To meet the requirements of this provision, there needs to be an indication that the psychiatrist was involved in the development of the PBSP, as specified in the wording of this provision J9, and that the required elements are included in the document. This provision focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral and/or psychiatric) in order to decrease the reliance on psychotropic medication. It was warranted for the treating psychiatrist to participate in the development of the behavior support plan via providing input or collaborating with the author of the plan. Given the presence of the IDT in psychiatry clinic, the PBSPs were being reviewed during a regularly scheduled psychiatric clinic, with additional reviews as clinically indicated. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. There were 38 meetings attended by psychiatry this review period, a reduction from 47 meetings attended during the previous monitoring review. From the manner in which the data were presented, it was not possible to determine the percentage of meetings attended, or if these ISP meetings were held in psychiatry clinic or as a separate meeting. There were no PBSP meetings included in the listing. If the PBSP meetings occurred in the scope of the psychiatric clinic, the psychiatry department should collect and provide data about this. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> The example highlighted in J8 outlined the continued problems of multiple medication regimen adjustments. Record review noted that the psychiatrists better documented the rationale for multiple and rapid medication adjustments, however, concern with regard to this practice remains. Many of the medication changes outlined in the case of Individual #154 were done in close temporal proximity to each other, which did not allow for the review of data to determine the benefit, or lack thereof, as a result of a specific regimen adjustment. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> Non-pharmacological interventions included references to behavioral supports, work programs, and outings. Conversely, a review of documentation revealed that in each psychiatry clinic, for the most part, psychiatry and the IDT members who were present reviewed target behaviors, instead of identified psychiatric target symptoms. The implementation of the psychiatric support plan may improve both the identification and monitoring of target symptoms. The comprehensive psychiatric evaluations noted recommendations for non-pharmacological interventions in a non-specific manner, however, review of the ISP documentation revealed identification of specific activities that	

#	Provision	Assessment of Status	Compliance
		individuals were interested in or that could be beneficial in assisting with symptom amelioration. Monitoring Team's Compliance Rating To meet the requirements of this provision, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision J9. The monitoring team agreed with facility self-assessment that this section continued to be in noncompliance. Therefore, this provision was rated as being in noncompliance with the following comments: • The psychiatrists were not able to routinely attend annual ISP meetings because of time constraint, but reportedly focused their attention on individuals deemed high risk with frequent behavioral challenges. • There was reportedly psychiatric review of the PBSP during psychiatric clinic. The monitoring team, however, had difficulty locating the summary of such data of psychiatric participation in this process.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	Policy and Procedure A review of DADS policy and procedure "Psychiatry Services," dated 5/1/13, noted that state center responsibilities included that the psychiatrist in collaboration with the IDT members must "determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." Review of "SASSLC Psychiatry Clinical Services Policy" dated 7/1/13 revealed that prior to the initiation of a medication, the "New Psychotropic Medication Justification Form" must be completed. It allowed for documentation regarding the risk versus benefit of treatment with a particular medication. Quality of Risk-Benefit Analysis The self-assessment noted that 23 new psychotropic medications were initiated for 18 individuals. The facility reported that 20 of 23 psychotropic medications were initiated on an emergency basis. Therefore, only 13% of these prescriptions were begun with routine orders and procedure. Data provided for these 20 new medications initiated on an emergency basis did not indicate whether the emergency medications were initiated during a regularly scheduled clinic, during a crisis, or due to result of the necessity of an emergency psychiatric consultation. The monitoring team understands that there were probably times when the emergency intervention with psychotropic medication was warranted, however, it is best to thoroughly review the risk-benefit analysis, when clinically feasible, via the formal consent process. A positive finding was that the facility reported that 23 of 23 of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		"New Psychotropic Medication Justification Forms" were signed by IDT members including the "psychiatric provider, primary care physician, and nurse." The monitoring team recommends the facility monitor the pattern of initiating emergency psychotropic orders and to ensure that the detailed elements required in the consent process are addressed in a timely fashion. Depending on the indication of the psychopharmacologic regimen, beginning an agent for the sole purpose of addressing maladaptive behavior on an emergency basis, not associated with a psychiatric diagnosis, may better be classified as a chemical restraint, depending on the clinical history. The management of consent will be addressed in J14. The "New Psychotropic Medication Justification Form" was initiated 11/1/13 to document the risk/benefit analysis with respect to new medication prescriptions. The form also included signature lines for the prescribing psychiatrist, behavioral health specialist, IDT members present in the clinic, primary care provider, behavioral therapy committee members, and human rights committee. While it was positive that psychiatry was providing information to the team regarding medications, additional work was needed. For instance, the form did not review medications that the individual was already prescribed with regard to the risk/benefit analysis and possible drug-drug interactions. • An example was Individual #95. She was prescribed Latuda, an atypical antipsychotic medication, to treat intermittent explosive disorder inclusive of symptoms of "self-abusive and explosive behavior that has responded poorly to both behavioral management and psychoactive medications." The "New Psychotropic Medication Justification Form" mentioned this individual's history of treatment with other antipsychotic medications, including Haldol and Risperidone for similar indications with mixed results. The form did not mention other medications prescribed for psychiatric indications, including Trazodone for primary insomnia and Ativan for anxiety, agitation, and intermittent explosive disorder. As discussed in J14, there were examples noted of "Psychiatry Department Consent for Use of Psychoactive Medication for Behavior Support." This document, generated by behavioral health staff, included information regarding the individual's diagnosis, medications, potential side effects, and potential benefits. Potential drug-drug interactions and side effects on this list were not adequate (in all examples) and, thus, would not suffice for consent. The risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. The success of this process will require a continued collaborative approach from the individual's treatment team, inclusive	

#	Provision	Assessment of Status	Compliance
		of the psychiatrist, PCP, and nurse. It will also require that appropriate data regarding the individual's psychiatric target symptoms be provided to the physician, that these data are presented in a manner that is useful to determine efficacy, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision. Given the manner in which the quarterly psychiatry clinics were conducted (e.g., thorough interviews and team discussion), the elements necessary for this documentation appeared readily available. Given the improvement in staff attendance at psychiatry clinic, as well as the increased amount of time allotted for each clinical consultation, the development of the risk/benefit analysis should continue as a collaborative approach during psychiatry clinic. Documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication along with drug-drug interactions, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Observation of Psychiatric Clinic</u> During some of the psychiatric clinics observed by the monitoring team, the psychiatric rationale for a particular medication regimen was discussed with the IDT and some of the components of the risk/benefit analysis were undertaken with helpful input from the clinical pharmacist. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. Recommendations include accomplishing this goal together with the IDT currently participating in psychiatry clinic, access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time will be necessary to set up the shell of the document. The current process involved the psychiatrist writing throughout the clinic and at times did not allow for their ongoing conversation with the IDT due to task of completing handwritten notes. <u>Human Rights Committee Activities</u> A risk-benefit analysis, if authored by psychiatry, but developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). <u>Monitoring Team's Compliance Rating</u> There was a need for assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially	

#	Provision	Assessment of Status	Compliance
		more dangerous, than the medications for all individuals prescribed psychotropic medications. The input of the psychiatrist and various disciplines must occur and be documented in order to meet the requirements of this provision. Although there were improvements noted with regard to psychiatric participation in the development of risk/benefit/side effect documentation, challenges remained. The behavioral health department continued to be responsible for the medical consent process for psychotropic medication instead of this being assigned to the prescribing practitioner/psychiatry staff. While the currently-implemented form addressed newly prescribed agents, it did not list other prescribed psychotropic agents. The facility reported that 87% of psychotropic medications were initiated on an emergency basis. Depending on the indication of the psychopharmacologic regimen, beginning an agent for the sole purpose of maladaptive behavior on an emergency basis, not associated with a psychiatric diagnosis, may better be classified as a chemical restraint depending on the clinical history. The facility should monitor the pattern of initiating emergency psychotropic orders and to ensure that the prescribing practitioner addresses the detailed elements required in the Risk-Benefit Analysis of the consent process. Given the issues outlined above, this provision will remain in noncompliance in agreement with the facility self-assessment.	
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	Facility-Level Review System The facility held the inaugural Polypharmacy Overview Committee (POC) meeting on 6/22/12. During this monitoring period, three committee meetings were held (10/22/13, 1/28/14, and 2/25/14) plus one during the onsite review on 4/29/14. In addition, there was documentation of a review of previous POC recommendations occurring on 12/31/13. Per this documentation, original recommendations resulting from the POC meeting were reviewed to determine if recommendations were addressed. A tally of the number of individual cases reviewed by POC was requested. It was reported that of a total of 104 individuals whose regimens met criteria for polypharmacy, 23 had been reviewed by POC. The self-assessment outlined that, as of 4/17/14, 151 of 154 (98%) individuals who received psychiatric services met criteria for being prescribed polypharmacy. These data indicated an increase in the percentage of individuals prescribed psychiatric polypharmacy as compared to the previous monitoring period where 76% of individuals receiving psychiatric services met criteria for polypharmacy. Data provided by the pharmacy indicated that 104 individuals receiving psychiatric services met criteria for polypharmacy (67%). These data differ substantially and must be reconciled.	Noncompliance

#	Provision	Assessment of Status	Compliance
	clinically justified are eliminated.	When utilizing data provided by pharmacy, calculations revealed that, if the facility continues with three POC meetings per monitoring period with an average of three individuals reviewed at each meeting, it would require approximately 27 meetings to complete the POC reviews, which at the current rate would take 4.5 years to complete. The POC meeting was observed during the monitoring visit and consisted of a review of the pharmaceutical regimens of selected individuals. There was not a critical review of the regimens per se, but rather a review of the case history, current treatment, and monitoring. Review of previous meeting minutes did not reveal documentation of the results of reviews of individual regimens, but did include plans for further monitoring. For example, for Individual #160, meeting minutes documented recommendations, including "cross taper Risperidone and Olanzapine if Risperidone appears effective… Risperidone ineffective and has been discontinued...consider challenging Bupropion in the future…will reconsider in future." <u>Review of Polypharmacy Data</u> Documentation presented during the Pharmacy and Therapeutics meeting 4/28/14 was reviewed. Per these data: • The total number of individuals residing at the facility prescribed two or more psychotropic medications of the same class was 37. This was an increase from 33 individuals reported in the previous monitoring period. • The total number of individuals residing at the facility prescribed three or more psychotropic medications was 67. This was an increase from 66 individuals in the previous monitoring period. • 67% of the individuals prescribed psychotropic medications at SASSLC met criteria for polypharmacy. This percentage is the same as that noted during the previous monitoring review. • The data reported above are significantly different than the data presented in the facility self-assessment where it was noted that 98% of individuals receiving psychiatric services were prescribed psychotropic polypharmacy. • Data revealed that for those individuals prescribed intraclass polypharmacy, the majority of individuals (61%) were prescribed antipsychotic intraclass polypharmacy. • Data regarding the number of individuals prescribed medications within a specific class (outside of those meeting the designation of intra-class polypharmacy) were not provided in the committee meeting. The total number of individuals residing at the facility prescribed any psychotropic medication (154) was provided to the monitoring team from the psychiatry department. There were challenges with the review of these data regarding intraclass polypharmacy for	

#	Provision	Assessment of Status	Compliance
		review of individuals prescribed two or more AEDs, either due to a seizure diagnosis and/or for psychiatric purposes. The facility should consider reviewing these data and revise the indications, if not accurate, for the medications and update the diagnostics in the document to be consistent across disciplines (i.e., diagnosis per psychiatrist to be cohesive with QDRRs, neurology consultation, etc.) In some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a vigorous discussion regarding reviews of the justification for polypharmacy derived by the IDT in psychiatry clinic. Monitoring Team's Compliance Rating The self-rating by the facility of noncompliance was supported by the monitoring team. This element was in the beginning stage as this provision not only required the implementation of a facility-level review system to monitor polypharmacy (at least monthly), but that medications that are not clinically justified are eliminated. Given the ongoing challenges (e.g., lack of a monthly meeting, review of regimens as opposed to critical review), this provision was rated in noncompliance. The facility must ensure a thorough facility level review of polypharmacy regimens and appropriately justify polypharmacy for each individual meeting criterion.	
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.	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) In response to the document request for a spreadsheet of individuals who had been evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and dates of completion of evaluations dated September 2013 through February 2014. The data were presented for each month, including the individual's name, DISCUS score, MOSES score, and the dates of completion. The manner in which the data were presented, however, made it difficult to follow the completion of the instruments over the course of time because data were not sequential. Therefore, it was not organized to compare scores over time. A revision in the presentation of data into a spreadsheet may assist with tracking both the completion of the instruments over time and changes in scores requiring further clinical evaluation. The self-assessment indicated that 131 of 154 (85%) individuals receiving psychiatric services had a MOSES and DISCUS scale completed on a quarterly basis from 9/1/13 to 12/31/13. For the 23 individuals who did not have timely assessments, it was documented that nine individuals "received MOSES/DISCUS evaluation by an extended month compared to the quarterly basis and 14 individuals received late DISCUS evaluations." In addition, it was reported the nurse from the psychiatry clinic had continued to review MOSES and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		DISCUS during clinics as defined by the policy for quality of clinical correlation in regards to potential side effects. <u>Training</u> Per the response to the request for information regarding inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations, there was "no evidence for file" for both this review and the previous monitoring visit. Additional information requested onsite revealed that in April 2014, four nurses attended training regarding MOSES and DISCUS. Information previously received noted that the MOSES and DISCUS were included in the annual nursing competency assessment, therefore, it would be helpful to summarize these data for future monitoring visits. <u>Quality of Completion of Side Effect Rating Scales</u> In regard to the quality of the completion of the assessments for the set of scales reviewed (10 examples of each assessment tool), most were completed appropriately and included the signature of the psychiatrist. In all examples, clinical correlation was documented on the evaluation form inclusive of the conclusion regarding the presence or absence of a diagnosis of Tardive Dyskinesia. During this monitoring review, it was noted that the previous MOSES/DISCUS scores were included on the "Psychiatry Clinic" form allowing for comparison of data from previous rating periods. Observation of psychiatry clinics performed during this monitoring period revealed that the psychiatric physician attempted to review both the MOSES and DISCUS during the clinic encounter. There were challenges with this process. Currently, MOSES and DISCUS assessment results were being entered into Avatar. In an effort to maintain appropriate documentation, the facility had previously continued with paper documentation of the assessments for review during clinic. During this monitoring visit, paper documentation of the assessments was not available in clinic. Staff reported that they were instructed not to provide paper documentation. This presented a serious challenge because there was no infrastructure for access to electronic documents from psychiatry clinic. This was an issue that had been identified by the Performance Improvement Team regarding MOSES/DISCUS on 12/17/13. Thirty-one individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). This was an increase from 26 individuals identified in the previous monitoring report. Although medications, such as antipsychotics and Reglan (Metoclopramide) may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Twenty-five individuals were prescribed Reglan and three (Individual #302, Individual #92, and Individual #199) were diagnosed with Tardive Dyskinesia.	

#	Provision	Assessment of Status	Compliance
		Medication reduction or the absence of the antipsychotic or Reglan that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnoses, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. <u>Implementation of Avatar</u> The facility had implemented the Avatar system. This was an electronic database where information, including MOSES and DISCUS results, could be stored. In the intervening period since the previous monitoring period, the Avatar system had been updated to allow for physician review and electronic signature of the assessment documents. While this was a good step, there were issues with this process. Specifically, although the document can be maintained electronically, the facility did not have the technological capabilities for the assessments to be retrieved during clinical encounters, necessitating the maintenance of paper documentation. <u>Monitoring Team's Compliance Rating</u> Given the documentation of clinical correlation present on the MOSES/DISCUS forms, the ability to compare results from previous rating scales due to the documentation included in the "Psychiatry Clinic" note, the inclusion of MOSES/DISCUS review in the "Quarterly Clinic Addendum-Treatment Plan Review," and the review of these rating scales during psychiatry clinic, this provision was placed in substantial compliance during the previous monitoring review. During this review, there were challenges with access to documentation of these assessment instruments during clinic. These challenges must be addressed for the substantial compliance rating to maintain in upcoming monitoring reviews.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 5/1/13, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." "SASSLC Psychiatry Clinical Services Policy" dated 7/1/13 outlined the requirements for psychiatric practice consistent with statewide policy and procedure. The facility had implemented the "New Psychotropic Medication Justification Form," which included information, such as the medication dosage, indications, risk/benefit analysis, alternatives to treatment, symptoms/behavioral characteristics to be monitored, and the expected timeline for therapeutic effects to occur. Diagnoses were addressed in the quarterly clinic notes. <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 13 individuals, there were treatment plans for psychotropic	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	medication included in the "Quarterly Clinic-Treatment Plan Review" documents. A review of documentation noted inclusion of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral-pharmacological treatment hypothesis). Other required elements including the expected timeline for the therapeutic effects of the medication to occur were included. One issue noted in records reviewed was the lack of consistency between diagnosis/medication and data points collected. <u>Psychiatric Participation in ISP Meetings</u> The information for psychiatric participation in ISP meetings was summarized above in J9. At the time of the onsite review, there was limited psychiatry participation in the ISP process. Given the manner of the data, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. In an effort to utilize staff resources most effectively, the facility essentially created an IDT meeting during psychiatry clinic, thereby incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT into psychiatry clinic allowed for improvements in overall team cohesion, information sharing, and collaborative case conceptualization. <u>Psychiatry Clinic</u> During this monitoring review, two psychiatry clinics were observed (one regularly scheduled and one emergency clinic). All treatment team disciplines were represented during the regularly scheduled clinical encounter. The team did not rush clinic, spending an appropriate amount of time (often 20-30 minutes) with the individual and discussing the individual's treatment. Prior to clinic, the various disciplines (e.g., behavioral health, nursing, psychiatry) documented information into the clinic note format in preparation for the clinical encounter. The individual's record was present in clinic, and the psychiatrist reviewed information in the record. During clinic, the psychiatrist made attempts to review behavioral data. Review of 13 records revealed that in general, data presentation had transitioned into a graphic format, making it easier to interpret. Challenges with data were that data points collected were not target symptom specific, which made data based decision making difficult for the psychiatrist with regard to determining the efficacy of a specific medication regimen. In observed clinical encounters, the individual's weights and vital signs were discussed, but the facility did not routinely obtain orthostatic vital signs for those individuals prescribed psychotropic medication that was known to cause orthostasis, not even during the time period of initial dosing titration, or when prescribed in combination with other medications used to treat hypertension, and/or with polypharmacy regimen. The individual's record and laboratory examinations were reviewed during the clinical encounter and documented	

#	Provision	Assessment of Status	Compliance
		in clinic notes. This was consistently noted in documents. The individuals enrolled in psychiatry clinic were reportedly seen at a minimum within a quarterly time frame. Given the manner in which data were provided, a confirmation based on data review was not possible. In addition, psychiatry was reportedly conducting many clinics on a monthly basis. This was discussed with the providers during this and the previous monitoring visit. The facility was not adequately staffed with psychiatric practitioners to allow for regularly reoccurring monthly clinics. It was acknowledged that some individuals do require monthly visits due to the acuity of their illness, however, if medication changes are made, follow-up can wait until the next regularly scheduled quarterly clinic to allow for accumulation of data in order to determine the individual's response to the medication alteration. <u>Medication Management and Changes</u> Medication dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter and a review of appropriate target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment. A medication taper should be considered to also reflect one dosage change a time, IDT to collect data, and then consider another dosage change depending on results of the information. Some individuals may be nonverbal and not be able to explain exactly when the presenting symptoms occurred during an ongoing medication taper across several weeks or months. It was common for the taper of medication at SASSLC to be ongoing, such as reduction of a medication every several weeks, instead of only one reduction of the medication and then collect further data before the next reduction. This process may be helpful for those prescribed long-term psychotropic medication to prevent withdrawal symptomatology and to assess for the possible emergence of abnormal motor movements and/or Akathisia. <u>Monitoring Team's Compliance Rating</u> Per a review of the facility self-assessment, this provision was rated in noncompliance "as evidenced by psychiatry attendance and/or electronic submissions of supporting documentation to IDT members indicating individual's current psychiatry status." The monitoring team rated this provision in noncompliance. The facility psychiatry staff made advancement with regard to development of a treatment plan for psychotropic medication that identified the expected timeline for the therapeutic effects of the medication to occur, however, improvements are necessary with regard to the identification of target symptoms and behavioral characteristics that would be monitored to assess the treatment's efficacy. Given these deficiencies, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and	<u>Policy and Procedure</u> Per DADS policy and procedure "Psychiatry Services" dated 5/1/13, "before prescribing	Noncompliance

#	Provision	Assessment of Status	Compliance
	with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	psychotropic medications…the state center must provide information about the psychotropic medications to individuals, their families, and/or their legally authorized representatives…must address characteristics of the medication, including expected benefits, potential adverse or side effects, dosage, and standard alternative treatments; legal rights; and any questions the individual, the family, and/or LAR have." In addition, DADS was reportedly in the process of developing a statewide policy regarding informed consent. This policy was pending at the time of this monitoring visit. Per the facility policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 7/1/13, the procedure for prescribing psychotropic medication included: "Initiation of a new psychotropic medication on an emergency basis: 'New Psychotropic Medication Justification Form' will be filled out by the psychiatry provider…if there is a LAR the psychiatry provider will make attempts during clinic to reach the LAR for verbal consent. If unable to reach the LAR, the psychiatry provider will continue to make attempts outside of clinic hours…for at least five working days thereafter…attempts to reach the LAR need to be documented in the integrated progress notes…" The process for initiation of a new psychotropic medication on a nonemergency basis was similar. The policy did not include procedures for annual medication consent. <u>Current Practices</u> Per the facility self-assessment, during this monitoring period, 10 of 23 (43%) individuals prescribed a new psychotropic medication had an LAR and 8 of 23 (38%) did not have a LAR, therefore, consent was obtained from the SASSLC director and the HRC/BTC. The facility provided a self-rating of noncompliance due to "insufficiently informed Psychotropic Medication Consent Form." It was reported that psychiatry did not participate in the annual consent process for utilization of psychotropic medication. This process remained inappropriately delegated to behavioral health staff. A review of information provided regarding consent information for the last 10 newly prescribed psychotropic medications revealed a document entitled "Consent for Use of Psychoactive Medication for Behavior Support." These documents named specific medications, however, it was noted that, in some cases, multiple medications were included in a single consent form. In addition, side effects were listed, but behavioral health staff authored these. Signed consent forms included the signature of the LAR, but did not indicate the name of the individual providing the information regarding the risks, benefits, side effects, or alternatives to treatment with a particular medication. For newly prescribed medications, documentation also included the "New Psychotropic Medication Justification Form." Information was typically complete, including the name of	

#	Provision	Assessment of Status	Compliance
		the medication, indication for the medication, a review of the risk/benefit, a listing of target symptoms, expected timelines for therapeutic effects of medication to occur, and signatures of all involved parties. This document did not include a listing of potential side effects of the medication, nor did include the names of other medications the individual was prescribed or potential drug-drug interactions. Monitoring Team's Compliance Rating Current facility practice was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian or party consenting to treatment) the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the record. This provision remained in noncompliance, in agreement with the facility self-assessment, due to the inadequate informed consent practices.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 5/1/13, "when medications are prescribed to treat both seizures and a mental health disorder, the neurologist and psychiatrist must coordinate the use of medications through the IDT process." Facility policy and procedure dated 7/1/13 included procedures for requesting a neurology consultation, and indicated that psychiatric physicians were required to attend neurology clinic for individuals assigned to their caseload, and outlined the process via which psychiatrists would communicate information obtained via neurology clinic with the IDT and the process by which recommendations would be implemented. The facility had compiled a manual of medical guidelines. This manual included seizure management guidelines. Per this document, "for individuals who are on both psychotropic drugs and anticonvulsants, the treating psychiatrist will be present in the neurology clinic so as to integrate care and reduce polypharmacy." This document also outlined the frequency for neurological consultation. Individuals with poorly controlled seizures "will be evaluated at least once per year or more frequently if recommended by the neurologist." Individuals with well controlled seizures will be evaluated at least "once every two years or at other internals recommended by the neurologist." Individuals with Seizure Disorder Enrolled in Psychiatry Clinic A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 73 individuals. Data provided via the facility self-assessment indicated eight individuals receiving psychiatric services were diagnosed with seizure disorder and were prescribed medications to treat both seizures and mental health symptoms. The self-	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment noted that, as of 2/28/14, three of these eight individuals had been seen for neurological consultation. It was not possible to determine when these individuals were last present in clinic or the length of time since the last consultation. <u>Adequacy of Current Neurology Resources</u> The neurologist was scheduled to evaluate individuals at SASSLC the second and last Tuesdays of every month starting at 10:00 am. Additional information presented revealed that the current consulting neurologist would conduct clinic at the facility once a month alternating with an epileptologist for a total of two neurology clinics monthly. Per the facility self-assessment, there were a total of nine neurology clinics during this monitoring period. A review of the document "Seizure Disorder Diagnosis Currently Receiving Psychiatric Services" included either the date of the last neurology consultation or a brief description of the rationale for the lack of a recent clinic encounter (e.g., "seizure free since 2007") for 73 individuals. There were seven individuals with notations indicating "seizure free." There were seven individuals where the notation "documentation of history, but insufficient documentation of neurology consultations" was made. Twenty-three of the individuals (non-inclusive of the 14 individuals with notations discussed above) had not been seen in neurology clinic in the previous year. One individual was last seen in 2005, one individual was last seen in 2006, three individuals were last seen in 2009, four individuals were last seen in 2010, four individuals were last seen in 2011, and 10 individuals were last seen in 2012. Given these data, it was evident that additional clinical neurology consultation was needed, and for the neurologist and psychiatrist to coordinate the use of medications. It would be beneficial for the IDT to review the cases of the individuals requiring neurology follow-up to ensure that they received annual neurology clinical consultation and neuropsychiatric consultation as outlined in this provision. As the physicians continue organizing and participating in this clinical consultation, they will need to determine if the current and/or expanded contract hours are sufficient. Given a four hour clinic twice per month, 24 times per year, there would be a total of 96 hours of consultation time to allocate between 73 individuals who had a seizure disorder and psychiatric disorder (this does not include other individuals requiring neurology services). Regardless, the facility should make efforts to maximize the utilization of their current neurology consultative resources and continue the pursuit of options for increasing neurologic consultation availability, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities.	

#	Provision	Assessment of Status	Compliance
		Monitoring Team's Compliance Rating Because SASSLC psychiatry had developed a clinic protocol where psychiatry clinics were integrated, requiring the participation of various IDT members, and allowing for a meeting of the IDT during psychiatry clinic, clinical coordination between neurology, psychiatry, and the IDT had improved. It was apparent that there had been ongoing efforts to integrate psychiatric clinicians into neurology clinic, as well as for psychiatric clinicians to be the conduit of information from neurology clinic to the IDT. Issues remained with regard to the referral of individuals to neurology clinic and with clinic follow-up, as well as adequacy of resources as evidenced by the delays in review outlined above. Given these issues, this provision will remain in noncompliance, in agreement with the facility self-assessment. In order to move toward substantial compliance, the facility must ensure adequate neurological resources, appropriate referral of individuals to neurology clinic, and ensure timely/annual clinic follow-up.	

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:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #128 (10/1/13), Individual #55 (10/9/13), Individual #120 (11/7/13), Individual #119 (10/31/13), Individual #283 (11/18/13), Individual #305 (10/25/13), Individual #285 (12/10/13), Individual #167 (1/7/14), Individual #349 (11/21/13), Individual #304 (11/5/13), Individual #39 (3/4/14), Individual #220 (2/11/14), Individual #290 (2/17/14) o Positive Behavior Support Plans (PBSPs) for: • Individual #291 (11/12/13), Individual #128 (11/25/13), Individual #55 (11/4/13), Individual #120 (12/9/13), Individual #119 (12/16/13), Individual #283 (12/9/13), Individual #305 (11/12/13), Individual #285 (1/16/14), Individual #167 (2/3/14), Individual #349 (12/16/13), Individual #304 (12/9/13), Individual #39 (3/31/14), Individual #220 (4/7/14), Individual #290 (3/3/14), Individual #254 (2/24/14) o Annual Psychological updates for: • Individual #291 (8/26/13), Individual #128 (10/1/13), Individual #55 (10/8/13), Individual #119 (12/12/13), Individual #120 (11/7/13), Individual #283 (11/18/13), Individual #305 (10/25/13), Individual #285 (12/10/13), Individual #167 (1/7/14), Individual #349 (11/21/13), Individual #39 (3/4/14), Individual #338 (3/18/14), Individual #290 (2/14/14) o Six months of progress notes for: • Individual #119, Individual #167, Individual #120, Individual #285, Individual #349, Individual #305, Individual #55, Individual #291, Individual #128, Individual #283 o Psychological treatment plans and progress notes for: • Individual #304, Individual #83, Individual #209, Individual #350, Individual #39, Individual #140, Individual #285, Individual #16, Individual #142 o Treatment integrity sheets for: • Individual #268 o PBSP readability scores (Flesch-Kincaid) for: • Individual #119, Individual #167, Individual #120, Individual #285, Individual #349, Individual #305, Individual #55, Individual #291, Individual #128, Individual #283 o Behavioral data system inservice power point, undated o List of all individuals who have PBSPs and dates of most recent revisions, undated o List of all individuals who have a functional assessment and date of the most recent revision, undated o List of the most recent revision of all individuals annual psychological evaluation, undated o List of the most recent revision of all individuals full psychological evaluation, undated

	○ Status of enrollment in BCBA coursework for each staff member that writes PBSPs, undated ○ For the past six months, minutes from meetings of the behavioral health department ○ Internal and external peer review minutes from September 2013 to February 2014 ○ SASSLC self-assessment, 4/17/14 ○ SASSLC action plans, 4/17/14 ○ Section K presentation book, undated ○ Description of the revised data collection system and sample data sheets, undated ○ A summary of all treatment integrity scores, 9/1/13- 2/28/14 <u>Interviews and Meetings Held</u>: ○ Charlotte Fisher, BCBA, Director of Behavioral Health Services ○ Charlotte Fisher, BCBA, Director of Behavioral Health Services; Melanie Rogers, BCBA, Behavior Analyst; Steven, BCBA, Behavior Analyst ○ Melanie Rogers, BCBA, Behavior Analyst ○ Megan Lynch, Behavioral Health Specialist ○ Emily Foster, Behavioral Health Specialist <u>Observations Conducted</u>: ○ Behavior Therapy Committee (BTC) Meeting • Individuals presented: Individual #13, Individual #170, Individual #61 ○ Internal Peer review • Individual presented: Individual #173 ○ Psychiatric Clinic meeting: • Psychiatrist: Dr. Luna • Individuals presented: Individual #93, Individual #171, Individual #104 ○ Observation of treatment integrity data of PBSPs for: • Individual #268
	Facility Self-Assessment: The monitoring team believes that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. SASSLC's self-assessment included many relevant activities in the "activities engaged in" sections, however, a few provision items in this self-assessment did not include activities that were identical to those found in monitoring teams report. For example, K4 's self-assessment included a review of the flexibility of the data system and review of progress notes. These are topics that are included in the monitoring team's review of K4. This self-assessment, however, did not include several additional items (i.e., graphing of target and replacement behaviors, evidence that data are used to make treatment decisions, demonstration that goal frequencies and levels of data collection timeliness and IOA are achieved) that are identified in this report as necessary to achieve substantial compliance with K4.

	The monitoring team suggests that the behavioral health services department review, for each provision item, the activities engaged in by the monitoring team (based on this report), the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made in the report. This should lead the department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, and the action plan components are more likely to line up with each other. Finally, it is suggested that the department review the criterion for compliance in the monitors' report, and ensure that the self-assessment use the same criterion for their self-rating. SASSLC's self-assessment indicated that K2, K3, K7, and K11 were in substantial compliance. The monitoring team's review was congruent with the facility's self-assessment. Because many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for SASSLC to make these changes, the monitoring team suggest that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: SASSLC did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance prior to this review, and demonstrated improvements in several additional items. These improvements since the last review included: • Implementation of a new more flexible, individualized data collection system (K4) • Improvement in data collection timeliness (K4) • Improved accessibility of data sheets to the DSPs (K4) • Evidence of consistent data-based treatment decisions (K4) • Increased number of replacement behavior graphs (K4/K10) • Evidence of consistent action recommended in the progress notes when individuals were not making expected progress (K4) • Initiation of the tracking of all individuals with full psychological assessments (K5) • Initiation of the tracking of time from the receipt necessary consents to the implementation of PBSPs (K9) • Improvements in the assessment of treatment integrity of PBSP implementation (K10) The areas that the monitoring team suggests that SASSLC work on for the next onsite review are: • Continue to increase the flexibility of the data system (K4) • Ensure that replacement behaviors are consistently included in the new data collection system (K4) • Consistently graph replacement behavior (K4/K10)

	• Reinitiate the collection of data timeliness and IOA data (K4/K10) • Ensure that all individuals have a full psychological assessment (K5) • Ensure that all functional assessments have the correct use of terminology, and that they contain recent assessments or reasons why they are not necessary (K5) • Ensure that counseling services treatment plans/progress notes are consistently complete (K8) • Ensure that each PBSP contains a functional replacement behavior, or an explanation why a functional replacement behavior is impossible or impractical (K9) • Demonstrate that established levels and frequencies of treatment integrity are achieved (K10)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the staff at SASSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as board certified behavior analysts (BCBAs). Nine of the 10 staff that wrote PBSPs (90%) either had their BCBA, or were enrolled, or completed coursework toward attaining a BCBA. This was similar to the last review when 88% of the facility's behavioral health specialists that wrote PBSPs were enrolled in or completed BCBA coursework. The facility maintained three BCBAs that wrote PBSPs (30%). The facility should ensure that all behavioral health specialists that write PBSPs have BCBAs. The director of behavioral health services was certified as a behavior analyst. She and the other BCBAs in the department provided supervision to the behavioral health specialists enrolled in BCBA coursework. SASSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each behavioral health specialist's BCBA training and credentials.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year,	SASSLC continued to be in substantial compliance with this provision item. SASSLC continued its weekly internal, and monthly external, peer review meetings. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	each Facility shall establish a peer-based system to review the quality of PBSPs.	internal peer review meetings provided an opportunity for staff to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team discussed the appropriateness of a PBSP or psychiatric support plan (PSP) for the management of Individual #173's target behaviors. The peer review meeting included active participation from all of the department's behavioral health specialists, and appeared to result in the beginning of a rationale for which individuals at SASSLC would benefit from each type of treatment plan. Review of minutes from internal peer review meetings indicated that the majority of staff that wrote PBSPs regularly attended peer review meetings. Additionally, meeting minutes from the last six months indicated that internal peer review meetings occurred in 24 of the last 27 weeks (89%), and that once in each of the last six months, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, SASSLC needs to provide documentation that internal peer review occurs during at least 80% of the weeks reviewed, external peer review occurs during at least 80% of the months reviewed, and there is evidence of follow-up/implementation of recommendations made in peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored	The monitoring team noted progress in this area. More work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. The primary improvement in this area was the individualization of the data collection system by increasing its flexibility. At the last review, the facility utilized a 30-minute partial interval data collection system in all residential and day programming sites. The new system, however, had the flexibility of five different intervals (i.e., hourly, every two hours, per shift, daily, and weekly) available, based on the needs of each individual. The majority of direct support professionals (DSPs) interviewed indicated that they liked the new data system. The monitoring team was encouraged by these improvements in the data system. At this point it is recommended that SASSLC continue to increase the flexibility of its data system by adding additional measures for target and replacement behaviors. Examples include frequency within intervals (when it is most important to evaluate how often the behavior occurs), and duration (when the total time the behavior occurred is the most valuable information, such as episodes of disruptive behavior).	Noncompliance

#	Provision	Assessment of Status	Compliance
	and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	In the new data collection system, DSPs were required to record a zero in each recording interval if the target behavior did not occur. Requiring the recording of a target behavior, or a mark indicating that no target behavior occurred, increased the likelihood that the absence of target behaviors in any given interval did not occur because staff forgot or neglected to record data. The requirement of a recording in each interval of the data sheet also allowed the staff that write PBSPs to review data sheets and determine if DSPs were recording data in a timely manner (as soon after the interval expires as possible). At the time of the onsite review, the facility had postponed their review of data collection timeliness. The monitoring team, however, did its own sample of data collection timeliness by sampling individual data sheets across several treatment sites, and noting if data were recorded up to the previous interval. The target behaviors sampled for 11 of 23 data sheets reviewed (48%) were completed within the previous interval. This represented a dramatic improvement from the last review when only 14% of the data sheets reviewed had data recorded in the previous interval. It is likely that this improvement in data collection timeliness is related to the new data system because, in the new data system, DSPs no longer need to record zeros every 30 minutes for behaviors that typically occurred very infrequently. At this point, it is recommended that SASSLC reinitiate the collection of data timeliness data, and performance feedback to DSPs, to further increase the recording of data as soon after the designated interval as possible. Another improvement since the last review was the accessibly of the data sheets to the DSPs. In past reviews, the monitoring team noted that data sheets were in the individual notebooks, and those notebooks were not consistently available to the DSPs (i.e., they were behind locked doors). In the new data system, two notebooks with only the data sheets were used. One notebook contained the data sheets for individuals with high tracking needs (i.e., hourly and every two hour intervals), and the other notebook contained the intervals for individuals with less intense tracking needs (i.e., once a shift, daily, weekly). All of the high tracking books were found on the floor (and accessible to the DSPs) in the residences and day programs. One area that continued to require attention was the inclusion of replacement behaviors in the new data system. Although the data sheets in the majority of treatment sites included replacement behaviors, the monitoring team encountered some data sheets (e.g., Home 766) with only target behaviors, but no replacement behaviors. The facility is urged to ensure that replacement behavior data are collected for all individuals with a PBSP. While data collection reliability assesses whether data are recorded in a timely fashion, interobserver agreement (IOA) assesses if multiple people agree that a target or	

#	Provision	Assessment of Status	Compliance
		replacement behavior occurred. As discussed above concerning data collection timeliness measures, SASSLC recently postponed the collection of IOA data. It is recommended that that the facility reinitiate the collection of IOA to assess and improve the reliability of its PBSP data. Further, it is recommended that the facility establish minimum frequencies (i.e., how often it is collected) and levels (i.e., what are acceptable scores) for the collection of data timeliness and IOA data. Finally, in order to achieve substantial compliance with this provision item, the facility will also need to document that the established minimal frequencies and levels of data collection timeliness and IOA are achieved. All of the graphs of target behaviors observed by the monitoring team were simplified (i.e., reduced number of data paths and addition of phase lines to mark medication changes and/or other potentially important events). Finally, although the monitoring team encountered graphs of replacement behaviors, none of the PBSPs reviewed included graphs of replacement behaviors. It is recommended that replacement behaviors be graphed in PBSPs or in progress notes for all individuals with PBSPs. The routine use of data to make treatment decisions represents another improvement. In all three of the psychiatric clinics observed by the monitoring team, the behavioral health specialist presented graphs that were current, clearly indicated when important environmental events occurred, and were simple to understand. The clear and current graphs contributed to data based decisions concerning the use of all three individuals' medications and/or interventions. In reviewing PBSP data in 13 individuals with at least six months of data for severe target behaviors (i.e., physical aggression, self-injurious behavior, elopement), nine (69%) indicated a lack of progress in at least one severe target behavior (i.e., Individual #55, Individual #119, Individual #305, Individual #285, Individual #167, Individual #349, Individual #220, Individual #39, and Individual #304). This represented a decrease from the last review when 50% of PBSPs reviewed indicated a lack of progress. An area of improvement for the facility is the documentation of action taken to address the lack of progress. For all of the individuals whom there was no obvious progress in severe target behaviors (100%), the progress notes documented specific staff actions to address the absence of target behavior change. For example, following a substantial increase in aggression, Individual #55's progress note indicated that much of the increase was associated with new staff, and that those staff would be retrained on Individual #55's PBSP. This represented an improvement from the last review, when 83% of progress notes of individuals with undesired results indicated some action to address the absence of target behavior change. There have been several improvements in this provision item, however, there continues	

#	Provision	Assessment of Status	Compliance
		to be much work needed to ultimately achieve substantial compliance with this provision item. Over the next six months, it is recommended that SASSLC focus on ensuring that replacement behaviors are collected and graphed for all individuals with PBSPs. Additionally, the facility needs to reinitiate the data collection timeliness and IOA collection procedures to ensure that target and replacement data are reliable.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of full psychological assessments for each individual, and the confusion of terminology in several functional assessments. <u>Psychological Assessments</u> A spreadsheet presented to the monitoring team indicated that 197 of the 235 individuals (84%) had full psychological assessments. No full psychological assessments were reviewed in this report because none were completed since the last review. All individuals at SASSLC should have a full psychological assessment. Additionally, these full psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status. <u>Functional Assessments</u> A spreadsheet provided to the monitoring team indicated that 165 of the 165 individuals with PBSPs (100%) had a functional assessment. This is the same as the last review when 100% of the individuals with a PBSP had a functional assessment. Additionally, 163 of the 165 functional assessments (99%) were current (i.e., written or revised in the last 12 months). This is consistent with the last review when 96% of functional assessments were current. The spreadsheet indicated that 60 functional assessments were completed in the last six months. Thirteen of these (22%) were reviewed to assess compliance with this provision item. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual and documentation of antecedent events that occurred prior to the target behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. As found in the last report, all of the functional assessments reviewed included acceptable indirect assessment procedures. All 13 of the functional assessments reviewed (100%) utilized direct assessment	Noncompliance

#	Provision	Assessment of Status	Compliance
		procedures that were rated as complete. This represented an increase from the last review when 90% of the functional assessments reviewed included a comprehensive direct assessment. Additionally, as found in the last review, all of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. Six of the 13 functional assessments reviewed (46%), however contained mislabeled setting events, antecedent conditions, and/or consequences. For example, Individual #120's functional assessment included precursor behaviors (i.e., behaviors that the individual engaged in that often predicted the target behavior) when listing potential antecedents to the target behaviors. Precursor behaviors (e.g., screaming, tearing items, etc.) can be useful to include in a functional assessment, however, they should not be called antecedents because they may confuse the reader. When comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. All of the 13 functional assessments reviewed (100%) included a clear summary statement. This is comparable to the last review when 100% of the functional assessments reviewed had a clear summary statement. Finally, Individual #283 and Individual #285's functional assessments had direct and indirect assessments that were several years old, without any statement as to if the results appeared to continue to be accurate. Annual functional assessment revisions should review the accuracy of direct and indirect assessment procedures and either redo direct and/or indirect assessment procedures, or state that the results of the past assessment procedures are believed to continue to be accurate. In summary, all 13 functional assessments reviewed (100%) contained the necessary components. Some common problems (i.e., confused terminology, absence of new direct or indirect assessments without explanation) need to be addressed in future functional assessments. In order to achieve substantial compliance with this provision item, SASSLC needs to ensure that at least 90% of all individuals have a full psychological assessment. Additionally, at least 85% of the full psychological assessments need to be judged as complete. SASSLC also needs to ensure that at least 90% of all functional assessments are current (i.e., revised at least every 12 months) and that at least 85% of all functional assessments are complete. Finally, the facility needs to ensure that antecedent	

#	Provision	Assessment of Status	Compliance
		conditions and consequences of target behaviors are accurately represented.	
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.	SASSLC's full psychological assessments were not consistently current, therefore, this provision item was rated as being in noncompliance. A spreadsheet of all individuals with psychological assessments indicated that five of 197 individuals with a full psychological assessment (3%) were current (i.e., conducted in the last five years). This represented an improvement from the last review when none of the individuals had current full psychological assessment (0%). All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
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.	SASSLC continued to be in substantial compliance with this provision item. In addition to full psychological assessments, SASSLC completed annual psychological updates. A spreadsheet provided the monitoring team indicated that current (i.e., reviewed/revised at least every 12 months) annual psychological updates were completed for 231 of the 235 individuals (98%). This is the same as the last review when 98% of the annual updates were current. A spreadsheet indicated that 110 annual psychological updates were completed in the last six months, and 13 (12%) of these were reviewed by monitoring team to assess their comprehensiveness. All 13 of the annual psychological updates reviewed (100%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status. Additionally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that three individuals were admitted to the facility in the last six months, and all three (100%) had a psychological assessment within 30 days of admission. In order to maintain compliance with this item of the Settlement Agreement, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have a psychological assessment completed within 30 days of admission.	Substantial Compliance

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K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	This item was rated as being in noncompliance because the treatment plans for psychological services other than PBSPs did not include procedures/plans to generalize skills learned or a fail criterion, and the progress notes did not appear to be directed related to the objectives. Psychological services other than PBSPs were provided for nine individuals at SASSLC. This is the same number of individuals provided psychological services other than PBSPs reported in the last review. A therapist outside of the facility provided counseling services to all of these individuals. Treatment plans and progress notes were reviewed for all nine individuals (100%) to assess compliance with this provision item. The treatment plans reviewed included the following: • A plan of service • Goals and measurable objectives • Qualified staff (i.e., psychologists with a degree in counseling) providing the services In order to achieve substantial compliance with this provision, the facility will need to demonstrate that at least 85% of psychological services other than PBSPs contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings Additionally, the facility needs to document the need for these services and that individuals that would benefit from these services receive it.	Noncompliance
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	This provision item was rated as being in noncompliance because PBSPs were not documented to be consistently implemented within 14 days of receiving consent, and the PBSPs did not consistently include functional replacement behaviors. A list of individuals with PBSPs indicated that 165 individuals at SASSLC had PBSPs. One hundred and sixty-three of these (99%) were current (i.e., reviewed/revised at least every 12 months). This is similar to the last review when 96% of PBSPs were current. As	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	reported in the last review, all PBSPs had the necessary consent and approvals. Since the last review, SASSLC began tracking the time from receiving consent to the implementation of the PBSP. At the time of the onsite review, the tracking was incomplete and did not include every PBSP. SASSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. Seventy-one PBSPs were completed since the last review, and 15 (21%) of these were reviewed to evaluate compliance with this provision item. As found in the last review, all PBSPs reviewed (100%) included operational descriptions of target and replacement behaviors. Additionally, all 15 of the PBSPs reviewed (100%) described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the stated function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This is identical to the last review when 100% of the PBSPs reviewed were judged to be consistent with the stated function. Replacement behaviors are often an effective component of a PBSP because they provide a desirable alternative behavior for individuals to access the reinforcers hypothesized to maintain the target behaviors. Replacement behaviors were included in 14 of the 15 (93%) PBSPs reviewed (Individual #305's PBSP was the exception). This is similar to the last review when 92% of all PBSPs contained replacement behaviors. All PBSPs should include replacement behaviors. Replacement behaviors should be functional (i.e., they should represent desired behaviors that serve the same function as the undesired behavior) when practical and possible. Replacement behaviors were found to be functional (when possible) for 10 of the 14 (Individual #55, Individual #285, Individual #290, and Individual #220 were the exceptions) PBSPs reviewed that contained replacement behaviors (71%). This represented a decrease from the last report, when 82% of all replacement behaviors that could be functional were functional. An example of a replacement behavior that was not functional was: • Individual #55's PBSP hypothesized that his physical aggression was maintained by staff attention, access to tangible items, and escape or avoidance of undesired activities. His replacement behavior was to hold a preferred item when walking to the dinning room. It may be the case that when Individual #55 walks with an item in his hand he is less likely to aggress toward others. Therefore, including this procedure in his PBSP would appear to be important. Having an item in his hand is not, however, a functional replacement behavior. In order to be functional, Individual #55's replacement behavior could be communicating that he desires staff attention, or a preferred item, or to have a break. In some situations, teaching an individual an appropriate way to attain desires may not	

#	Provision	Assessment of Status	Compliance
		be practical (e.g., escaping necessary medical demands) or possible (e.g., an automatically reinforced behavior). In those situations, it is important that the PBSP indicate why a functional replacement behavior was not practical or possible. An example of a functional replacement behavior was: • Individual #119's PBSP hypothesized that the function of her physical aggression was to escape or avoid undesired activities, and to gain access to preferred items. Her PBSP included a replacement behavior of communicating her desire to be left alone or for a desired item staff. When the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire, the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. Overall, 10 (Individual #128, Individual #291, Individual #120, Individual 119, Individual #283, Individual #167, Individual #349, Individual #304, Individual #39, and Individual #254) of the 15 PBSPs reviewed (67%) represented examples of comprehensive plans that contained all of the following items. This was the same as the last review when 67% of the PBSPs reviewed were judged to be acceptable. • rationale/purpose of the plan • operational definitions of target behaviors • operational definitions of functional replacement behavior • behavioral objectives for one or more target behaviors • behavioral objectives for one or more replacement behaviors • use (or stated why not) SAPs to address the acquisition of replacement/alternative behaviors • baseline data for one or more target behavior • antecedent-based or preventative strategies • strategies to promote replacement or alternative behavior • consequence-based strategies (what to do when behavior occurred) • the use of positive reinforcement • descriptions of data collection procedures • signed and dated Over the next six months, it is recommended that the facility document that PBSPs are consistently implemented within 14 days of receiving consent. Additionally, SASSLC should ensure that all PBSPs have functional replacement behaviors, or explain why functional replacement behaviors are not practical or possible.	

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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.	There were improvements in this provision item, however, more work (discussed below) is required before it could be rated as substantial compliance. As discussed in K4, SASSLC recently postponed the collection of IOA data. It is recommended that that the facility reinitiate the collection of IOA. Further, it is recommended that the facility establish minimum frequencies (i.e., how often it is collected) and levels (i.e., what are acceptable scores) for the collection of IOA data. Finally, in order to achieve substantial compliance with this provision item, the facility will also need to document that the established minimal frequencies and levels of IOA are achieved. All of the DSPs asked about PBSPs indicated that they understood them (see K11). The most direct method, however, to ensure that PBSPs are implemented as written is to regularly collect treatment integrity data. SASSLC continued to conduct treatment integrity. Prior to the last review, the facility established minimum frequencies for the collection of treatment integrity (i.e., how often it is collected) based on the severity and frequency of the target behavior. Additionally, the facility identified minimal treatment integrity levels (i.e., what are acceptable data collection reliability scores) at 90%. The facility reported that from 9/1/13 to 2/28/14, treatment integrity averaged 63%. The director of behavioral health services indicated that the frequency of treatment integrity collection had not been consistent with the facility's established goal. It is now recommended that the facility demonstrate that their goal frequency and level of treatment integrity is achieved. The monitoring team reviewed the treatment integrity data sheet used at SASSLC and believes it represented an adequate measure of treatment integrity. It included several relevant questions concerning the implementation of PBSPs (e.g., what are the target behaviors, what are the antecedents to the target behaviors) and a direct observation component where the behavioral health services specialist/assistant observed the DSP implementing the plan. Target behaviors were consistently graphed. All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines/indicators, data points, and a data path. Although the monitoring team found more examples of graphed replacement behaviors than in the last review, it is recommended that replacement behaviors be graphed for all individuals with PBSPs (see K4).	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DSPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item continued to be rated as being in substantial compliance.	Substantial Compliance

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	PBSPs are written so that they can be understood and implemented by direct care staff.	The behavioral health services department reviewed all PBSPs that were presented in peer review and the Behavior Therapy Committee to ensure that they were simple, clear, and written in a style that would promote staff understanding. The monitoring team reviewed 15 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 3.4 target behaviors per PBSP reviewed), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, SASSLC monitored the reading level (using the Flesch-Kincaid Readability score) of a sample of 10 PBSPs. The average reading grade level was 8.2. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs indicated that the plans were simple, clear, and easy to understand.	
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.	This item was rated as being in noncompliance because, at the time of the onsite review, SASSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the behavioral health department maintained logs documenting staff members who had been trained on each individual's PBSP. Behavioral health specialists and behavior analysts conducted the trainings prior to PBSP implementation and whenever plans changed. No trainings of staff on a PBSP occurred during the onsite visit, therefore, the monitoring team could not observe the training of DSPs on individual PBSPs. During past reviews, however, trainings were found to be thorough and included a review of the PBSP by a member of the behavioral health services department, an opportunity for DSPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to each individual's PBSP. The facility indicated that they maintained inservice logs on all staff training. They reported, however, that float staff were inserviced by the residential staff and they did not know the method used to train these staff. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual, including float/relief staff, has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	Noncompliance

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K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA for every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SASSLC had a census of 235 individuals and employed three behavior analysts and seven behavioral health specialists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants, and one psychology technician. In order to achieve compliance with this provision item, the facility must have at least eight behavior analysts (i.e., staff with BCBAs).	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ Health Care Guidelines, May 2009 ○ DADS Policy #009.2: Medical Care, 5/15/13 ○ DADS Policy Preventive Health Care Guidelines, 8/30/11 ○ DADS Policy #006.2: At Risk Individuals, 12/29/10 ○ DADS Policy #09-001: Clinical Death Review, 3/09 ○ DADS Policy #09-002: Administrative Death Review, 3/09f ○ DADS Policy #044.2: Emergency Response, 9/7/11 ○ DADS Clinical Guidelines ○ SASSLC Policy and Procedures: • Facility Medical Services Policy, Procedure 200-5A, 3/24/14 • Clinical Death Review, SOP, 300-23 CDR, 3/09 • Minimum Common Elements of Care, 10/14/13 • Continuous Quality Improvement Committee, 4/17/12 • Pneumonia Review Committee, 4/10/12 • Lab Matrix, 9/28/11 ○ Pneumonia Review Committee meeting minutes ○ Medical Continuous Quality Improvement Committee Meeting Minutes ○ Clinical Daily Provider Meeting Minutes ○ Listing of Medical Staff ○ Medical Caseload Data ○ Medical Staff Curriculum Vitae ○ Primary Provider CME Data ○ APRN Collaborative Agreement ○ Medical Department Employee CPR Data ○ Mortality Review Documents ○ Avatar Pneumonia Tracking Data ○ External Clinic Tracking Log ○ Internal Clinic Tracking Log ○ Listing, Neurology Clinics ○ Internal and External Medical Reviews ○ Listing, Individuals with seizure disorder ○ Listing, Individuals with history of status epilepticus since last compliance review ○ Listing, Individuals with diagnosis of refractory seizure disorder ○ Listing, Individuals with VNS ○ Listing, Individuals with pneumonia ○ Listing, Individuals with a diagnosis of osteopenia and osteoporosis

	○ Listing, Individuals over age 50 with dates of last colonoscopy ○ Listing, Females over age 40 with dates of last mammogram ○ Listing, Females over age 21 with dates of last cervical cancer screening ○ Listing, Individuals with DNR Orders ○ Listing, Individuals with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD ○ Listing, Individuals hospitalized and sent to emergency department ○ AED Polypharmacy Data ○ Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #57, Individual #43 Individual #136, Individual #288, Individual #119, Individual #242 Individual #313, Individual #170, Individual #132, Individual #74, Individual #13 ○ Annual Medical Assessments the following individuals: • Individual #300, Individual #280, Individual #124, Individual #2, Individual #13, Individual #199, Individual #57, Individual #39, Individual #268, Individual #30, Individual #167, Individual #249, Individual #73, Individual #287, Individual #306 ○ Neurology Notes for the following individuals: • Individual #114, Individual #164, Individual #292, Individual #104, Individual #110, Individual #30, Individual #344, Individual #254, Individual #142, Individual #165 <u>Interviews and Meetings Held</u>: ○ David Espino, MD, Medical Director ○ David Bessman, MD, Primary Care Physician ○ Jetta Brown, MD, Primary Care Physician ○ John J. Nava, MD, Primary Care Physician ○ Helen Starkweather, RN, APN,MSN,FNP-BC, Nurse Practitioner ○ Sharon Tramonte, Pharm D, Clinical Pharmacist ○ Mandy Pena, RN, QA Nurse ○ Chip Dunlap, RN, MSN, MHA, Chief Nurse Executive ○ Larry Algueseva, QA Director ○ Robert Zertuche, RN, Program Compliance Nurse <u>Observations Conducted</u>: ○ Daily Clinical Services Meetings ○ Medical Staff Meeting ○ Observations of homes ○ Medical Continuous Quality Improvement Meeting ○ Medication Variance Meeting

	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. The self-assessment provided little indication of the status of services provided. For section L1, six activities were reported, but the results of the activities were not documented and had no correlation to the activities. For example, one activity was to review 124 of 136 AMAs to determine if they were current. There was no documentation of the number of AMAs that were submitted in a timely manner. Similarly, QMSs were reviewed to determine if they were current, but no result of this activity was provided. Another activity was to review the morning meeting minutes to determine if discussions were integrated. There was no outcome documented for this activity. That is, activities were listed, but no results were provided. The results of the self-assessment included statements, which were not connected to the activities conducted. One statement was that for the 89 females who received gynecology exams, 71% had ben done. There was no activity conducted related to the review of preventive care. This pattern of random data unlinked to any specific activity was seen throughout the entire section L self-assessment. The facility's self-assessment should include metrics similar to those used by the monitoring team. The facility rated itself in noncompliance with all four provisions. The monitoring team concurred with the facility's self-rating.
	Summary of Monitor's Assessment: The medical department had functioned with several locum tenens providers since the October 2013 compliance review. At the time of this review, the department was fully staffed with three full time primary care providers and a medical director. All were facility employees. Having a stable medical staff was important because the medical department had a number of challenging issues to face. Quality health care for individuals includes two fundamental elements: the appropriate preventive care to lessen future health decline and the appropriate treatment for acute/current illness. Troubling findings surfaced in both areas during the conduct of this review. Unacceptable gaps were noted in the provision of routine health care. Some services, such as immunizations, were provided with high rates of compliance and improvement was seen in the compliance with vision screenings. However, compliance with many cancer screenings was poor based on record reviews. There were also concerns identified with the management of acute medical conditions. A clinical scenario was presented in the morning meeting that described an individual with respiratory compromise who was not evaluated by a physician until the PCP arrived the following morning. The individual was immediately transferred to an acute care facility and was admitted to the intensive care unit. Other individuals were identified through record reviews who were never assessed by a physician for acute medical problems, but should have been.

	Record and document reviews indicated that access to some specialty care was either not adequate or was not being appropriately utilized. The facility did not maintain any data to demonstrate timeliness of appointments. Records included in the record sample and other documents provided evidence of appointments that did not occur in a timely manner. Several of the records in the neurology sample documented a lack of clinic follow-up. There were outstanding cardiology appointments for evaluation of abnormal EKG findings and one pending "urgent' cardiology evaluation. The facility had a relatively high incidence of pneumonia. Throughout the week of the compliance review, the monitoring team attended the daily clinical meetings and learned of five individuals that were hospitalized with pneumonia. During one of the morning meetings, one member of the medical staff commented that the facility had many individuals with pneumonia. It was concerning that there had been no additional review of this trend. Similarly, there were numerous individuals hospitalized with bowel associated issues, such as bowel obstruction, ileus, and constipation. This was clearly documented in the hospital data, but no further analysis of the data had occurred. As noted in previous reviews, the facility submitted no justification for the DNRs. In fact, the table submitted appeared to include the same outdated data submitted for the October 2013 review. The external medical reviews were completed as required. Internal audits were also completed. This process was not clear because the medical director reported that the internal audits were completed in January 2014 and July 2013, however, data for an October 2013 audit was submitted following the onsite review. There were eight deaths since the last compliance review and 75 percent of the deaths involved the diagnosis of pneumonia. During the customary mortality management discussion, it was reported that the facility had taken a critical look at all deaths and there were no unusual findings. It was also reported that state office was reviewing deaths and providing recommendations, but had none for SASSLC. The Continuous Medical Quality Committee continued to develop metrics and met on a monthly basis. The committee members were trained on the use of root cause analysis and were beginning to utilize this problem solving methodology. Additional policies and guidelines were developed to guide the provision of medical care. Manuals were developed that included the facility's clinical guidelines. It was not clear that the physicians utilized this information. Throughout the conduct of this review, it was evident that compliance with existing policies, procedures, and guidelines was an ongoing challenge for the medical staff. This should improve since the facility will no longer rely on temporary physicians for staffing. Finally, some components of this review were hampered by the lack of accurate data. This is not problematic just for the compliance review. The medical department cannot measure its own progress if it cannot collect and report data accurately. Establishing a standardized set of quality measures, collecting and reporting data, is a required component for any health care delivery system.

	In addition to problems with data accuracy, the facility also appears to have problems maintaining documents and records. During the October 2013 review, an individual experienced a major medication error. When documents related to that error were requested, the monitoring team was informed that they were "lost." Similarly, for this review, an individual experienced an adverse outcome associated with anesthesia. The documents containing the information central to this case were reported as "nowhere to be found." While corrective actions have been implemented, it is important that the facility understand the gravity in failing to maintain the treatment records for individuals.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of a medical director, two full time staff primary care physicians, and one full time advanced practice registered nurse. There was one full time locum tenens primary care physician who the medical director reported was assisting with completion of assessments and would be leaving at the end of May 2014. The medical director carried a caseload of 19 while the APRN's caseload was about 60. The primary care physicians carried an average caseload of 80. The medical compliance nurse who began working at the facility 7/16/13 continued in that capacity. The collaborative agreement for the APRN was reviewed. It was signed by all members of the primary medical staff. CPR certification was current for all members of the medical staff. **Physician Participation In Team Process** <u>Daily Clinical Services Meeting</u> The facility continued its daily clinical services meeting. The medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacists, habilitation staff, and behavioral health specialists attended this morning review. The events of the past 24 hours were discussed, including hospital admissions, transfers, use of emergency drugs, and restraints. The meeting also included discussions related to admissions, discharges, clinic consultations, and adverse drug reactions. The meetings were informative with good participation by all clinical disciplines.	Noncompliance

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		ISP Meetings The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data presented in the self-assessment, for the months of September 2013 through February 2014, were submitted, and are summarized in the table below.	

Primary Care Provider ISP Attendance 2013 - 2014		
	Number of ISPs	Meetings Attended (%)
Sep	21	8 (38%)
Oct	22	11 (50%)
Nov	22	7 (31%)
Dec	18	7 (38%)
Jan	22	9 (41%)
Feb	16	9 (56%)
Total	121	51 (42%)

Over the six-month period, the primary providers attended a total of 51 of 121 (42%) of annual ISPs. This was an increase from the 24% participation seen during the previous compliance review. The primary care providers attended 13 of 37 (49%) ISPAs that were conducted during the months of September 2013 to February 2014. Two physicians accounted for 72% of the attendance.

Overview of the Provision of Medical Services

The medical staff conducted rounds in the homes of the individuals who received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite neurology, dental, podiatry, dermatology, gynecology, ophthalmology, and psychiatry clinics. Referrals for other specialty services were provided at the university health sciences center or by community physicians. It was reported that contracts were being negotiated with a cardiologist and pulmonologist to conduct onsite clinics. As will be discussed in the various sections of this report, tracking the provision of services was at times difficult.

The medical director reported that individuals were admitted to Nix Hospital. This was a full service hospital and could address all needs with the exception of neurosurgery. The medical staff had access to the records of individuals hospitalized at the Nix hospital. Individuals with true medical emergencies were transported to the closest most appropriate facility. Labs were drawn and processed at the facility and sent to Austin State Hospital. Stat labs were completed through Baptist Health Systems. A mobile x-ray service provided services 24 hours/day seven days a week.

While many basic health needs of individuals were met, there was evidence that improvement was needed in many areas. Deficiencies were noted in the provision of

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		some services. Preventive, routine, and specialty care were not consistently provided in a timely manner as several individuals had lapsed clinic appointments and delinquent screenings. Numerous individuals were also identified who were overdue for EKGs, many by several years. Records and documents indicated that lab studies were not consistently ordered per protocol. In addition to problems with the provision of services, there were issues related to care provided by the primary providers. Follow-up of individuals with acute medical problems and those returning from the hospital was sometimes inadequate. Record documentation revealed that individuals were frequently seen only once or twice. There was documentation that medication changes did not occur as needed and abnormal EKGs were not adequately addressed. Individuals who completed dental treatment with TIVA did not have documentation of appropriate medical evaluation prior to the procedure in order to determine overall risk. Management of pneumonia continued to present challenges, particularly for those individuals with recurrent pneumonia. Additionally, there were a number of individuals transferred to acute care facilities for management of bowel issues. Some of these individuals required surgical intervention. Discussions of the improvements as well as the opportunities for improvement are included throughout this report. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content. For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) records included an AMA • 10 of 10 (100%) AMAs were current • 9 of 10 (90%) AMAs included comments on family history • 9 of 10 (90%) AMAs included information about smoking and/or substance abuse history • 9 of 10 (90%) AMAs included information regarding the potential to transition	

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		The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 13 of 15 (86%) AMAs were completed in a timely manner. • 13 of 15 (86%) AMAs included comments on family history • 14 of 15 (93%) AMAs included information about smoking and/or substance abuse history • 15 of 15 (100%) AMAs included information regarding the potential to transition The AMA was considered timely if it was completed within 365 days of the previous summary. The format of the AMAs varied. The facility submitted sample included 15 AMAs that were completed in 2014. Eleven of 15 (73%) of the evaluations were completed in the old format. Four AMAs were done using the most recent state-issued template. The four assessments done in the new format were all completed by the medical director. Many of the assessments continued to present information in a disjointed manner, failing to link relevant problems, such as dysphagia, GERD, and pneumonia. In some instances, significant problems, such as recurrent pneumonia were not listed as an active problem. As a result of this, the primary medical provider included no discussion of the supports that were needed to prevent recurrence. The AMAs did not include any assessment of risk by the PCPs. Thus, none of the annual evaluations effectively outlined a plan to mitigate risks or adequately described the supports for individuals who were at risk for issues, such as aspiration, osteoporosis, or bowel issues. The plans of the assessment will continue to need to be refined. Many of them cited "continue current treatment" as the plan. This was primarily seen in AMAs completed by locum tenens physicians. <u>Quarterly Medical Summaries</u> Generally, the primary care providers were not completing the Quarterly Medical Summaries as required by the Health Care Guidelines. For the records contained in the record sample: • 3 of 10 (30%) records included a current QMS	

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		The QMSs completed were done using a state-issued template. Most records did not have a current QMS and several had not had summaries done in many months. It was clearly noted in the previous monitoring report that one provider was not completing QMSs. The records for that same provider once again did not have any quarterly summaries. In fact, the most recent summaries in the records for that provider were dated 2011. The completion of quarterly medical summaries is a requirement of the Health Care Guidelines and the medical director should address this requirement with the primary providers. <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL The APLs were found in most records and appeared to have updates added in many instances. <u>Integrated Progress Notes</u> Most physicians documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. The documentation of one primary provider was essentially illegible. This provider also consistently did not document in SOAP format. Documentation was infrequent. Generally, there were inadequate IPN notations when individuals experienced acute medical problems. Documentation of resolution of acute issues was rare. State-issued policy required that documentation related to acute medical problems continue until the problem was stable or resolved. Post-hospital documentation also required improvement. In many cases, IPN entries were identified for one, sometimes two days following hospital return. Compliance with documentation requirements was provider specific. <u>Physician Orders</u> Physician orders were usually dated, timed, and signed. The primary concern was incomplete orders, specifically orders written without indications. Medication orders are discussed further in section N1. <u>Consultation Referrals</u> The medical staff documented consultations in the IPN. A brief summary was typically noted. Some providers indicated agreement or disagreement with the recommendations of the consultant. Referral to the IDT was generally not indicated.	

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		The medical director reported that a new consultation form was recently implemented to ensure that physicians documented agreement/disagreement and referral to the IDT. The medical director believed fulfilled the requirements for documentation. State policy required specific documentation in the IPN in accordance with the health care guidelines and Settlement Agreement. Consultation referrals are discussed in further detail in section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals at the facility. Compliance with vision exams and screenings improved since the last onsite review. The medical director reported that formal audiology testing was being performed on all individuals because documentation of functional hearing assessed during the annual physical examination did not meet requirements during the most recent licensing survey. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. During the April 2013 and October 2013 compliance reviews, the medical director reported that all preventive care data needed to be re-established because it was lost with changes in staff. During both of those reviews, the data were either not submitted or were notably inaccurate. Databases were reported to be "works in progress." Twelve months after the staffing changes, the medical director continued to report that data entry for the preventive care databases was not complete. The medical compliance nurse, however, indicated that data were complete and reflected the status of preventive care at the facility. The record audits and other data submitted for the October 2013 review documented relatively poor compliance with the preventive care policy of the facility. Recommendations to address cancer screenings and other deficiencies related to preventive care were made in the monitoring report. During this compliance review, the monitoring team requested a sample of mammogram and colonoscopy reports. These reports were requested because facility data indicated that some tests were being ordered in a manner that was not consistent with guidelines. Specifically, females appeared to have repeat mammograms. The medical director indicated that those studies could have been completed at those intervals even though repeat studies would not be consistent with current guidelines. A review of sample reports documented a significant degree of inaccurate information in the reports submitted by the facility. In numerous instances, diagnostics were reported as "done" when the appointments and evaluations were not completed. • Due to the inaccuracy of the reports reviewed, the facility's preventive care data will not be presented in this report. The findings regarding preventive care are based on the 10 record audits only.	

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		Preventive Care Flow Sheets For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 5 of 10 (50%) forms were updated with the most recent AMA The Preventive Care Flowsheets were found in all of the records reviewed. It covered the basic areas of prevention and overall was adequate. The guidelines were generally consistent with state-issued guidelines. The documents were frequently not fully updated and there was no requirement for a physician signature resulting in the inability to determine which staff made the entries. The monitoring team recommends that the documents be updated with completion of quarterly and annual medical summaries. Immunizations • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 8 of 10 (80%) individuals had documentation of varicella status The active records included no documentation in the immunization records, IPNs, or physician orders regarding the provision of the Vaccine Information Statements (VIS). State policy indicated that informed consent was to be obtained for all immunizations. However, medical policy did not explicitly state the requirement for provision of the VIS or the documentation of the VIS. The National Childhood Vaccine Injury Act requires that all health care providers in the US, who administer to any child or adult certain vaccinations such as, but not limited to, varicella, tetanus, influenza, and hepatitis B, provide prior to administration of each dose, a copy of the "relevant current edition VIS produced by the CDC." Health care providers are also required by this federal law to "make a notation in each patient's permanent medical record at the time vaccine information materials are provided" the version of the VIS and the date provided. This is a requirement in addition to noting the vaccine manufacturer and name of the person administering the vaccine. Screenings • 7 of 10 (70%) individuals received appropriate vision screening • 7 of 10 (70%) individuals received appropriate hearing testing During the previous compliance review, the compliance with vision screenings and examinations decreased. The facility had focused on correcting this problem.	

#	Provision	Assessment of Status	Compliance
		Prostate Cancer Screening The facility suspended routine prostate cancer screenings based on recommendations of the US preventive Task Force. Per SASSLC medical policy, the decision to screen was made for each individual by the IDT due to continued controversy regarding the standard for this screening. SASSLC should seek further guidance from state office in this area. Breast Cancer Screening • 3 of 4 females met criteria for breast cancer screening • 1 of 2 (50%) females had current breast cancer screenings Cervical Cancer Screening • 4 of 4 females met criteria for cervical cancer screening • 2 of 4 (50%) females completed cervical cancer screening within three years Colorectal Cancer Screening • 5 of 10 individuals met criteria for colorectal cancer screening • 1 of 5 (20%) individuals completed colonoscopies for colorectal cancer screening within the past 10 years **Disease Management** The facility implemented numerous clinical guidelines based on state-issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. The management of chronic conditions is discussed below. Pneumonia The facility submitted data on the number of pneumonia cases. Those data are summarized in the table below.	

Pneumonia 2013 - 2014							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Aspiration	0	1	0	1	2	1	0
Pneumonia	0	1	0	8	1	5	1
Total	1	2	0	9	3	6	1

The Pneumonia Review Committee conducted two meetings since the last compliance review. The facility submitted notes for meetings held on 12/11/13 and 1/14/14. Checklists were completed for each individual. Information reviewed included CXR findings, lab data, hospital diagnosis, signs/symptoms of pneumonia, and pneumonia risk factors. The forms were not dated nor were they signed by a committee chair or the

#	Provision	Assessment of Status	Compliance
		medical director. The monitoring team was not clear on how the committee made decisions. For example, Individual #38 had a chest x-ray that showed a new left lower lobe infiltrate, but the group decided this was not consistent with pneumonia. The review process did not provide documentation that diagnostic and therapeutic modalities were adequately reviewed for each individual to ensure that the necessary supports were implemented, particularly for individuals with recurrent pneumonia. The committee did not appear to make any recommendations to the IDT regarding the supports or further actions that were needed. The Pneumonia Review Committee was a multidisciplinary committee that was capable of providing feedback to the IDTs with regards to the management of pneumonia. State protocols provided guidance on management of recurrent aspiration. Committee members should review the algorithms for management of pneumonia and recurrent aspiration and provide feedback to the IDTs through the pneumonia review process. In addition to the Pneumonia Review Committee, the medical director participated in the PNMT committee, which reviewed pneumonia. The primary care providers were also present for discussion of individuals in their caseloads. <u>Diabetes Mellitus</u> The records of 10 individuals were reviewed for adherence to the standards of care in in five areas set forth by the American Diabetes Association. Data are presented below: • 7 of 8 (87%) individuals had adequate glycemic control (HbA1c <7) • 8 of 8 (100%) individuals had annual eye examinations • 0 of 8 (0%) individuals received ACE/ARB for renal protection • 8 of 8 (100%) individuals received the pneumococcal and influenza vaccinations. Three individuals had HbA1c <u>≤</u> 5.5 and received no medication. It was not clear if these individuals had diabetes mellitus or were "pre-diabetic." One individual had a HbA1c of 9.5. None of the individuals received ACE inhibitors or ARBs. Those individuals with a diagnosis of diabetes should be reviewed to determine if they are candidates for treatment. There were no audits, apart from the medical management audits, conducted to ensure that individuals received the appropriate management of diabetes mellitus. The medical management audits did not sufficiently cover the key diabetes metrics. Neither the medical director nor medical compliance nurse was clear on the use of a diabetes	

#	Provision	Assessment of Status	Compliance
		tracking flow sheet. Record reviews indicated that there was no specific diabetes flow sheet. However, the PCFS included some aspects of diabetes management. As already noted, the PCFSs were not updated annually with each AMA as required. Many studies show that flowsheet use improves care and adherence to guidelines. The medical staff should update the diabetes section of the PCFS. <u>Constipation</u> There were 11 admissions related to bowel obstruction, ileus, or constipation from August 2013 to February 2014. There were several individuals at the facility that had undergone surgical procedures, such as colostomy or ileostomy. Other individuals were transferred to the emergency department for evaluation due to constipation. The medical director was questioned about the hospital data included in the CQI minutes because it clearly noted several admissions due to bowel problems. It was reported that several of these were due to Ogilvie's syndrome and other non-mechanical causes. Even though there were several individuals hospitalized, there had been no further review of bowel management at the facility. A DUE related to anticholinergic burden and bowel obstruction was conducted. However, further analysis of the hospital data would appear to be indicated. The facility should also review the current bowel management protocols and implementation of those protocols to ensure that optimal bowel management is occurring. **Case Examples** Individual #170 • This individual had several episodes of syncope. On 4/7/14, an order was written for an "urgent" cardiology consult. As of 5/5/14, the urgent consult had not been obtained. Individual #43 • This individual received lithium. There were no labs obtained from June 2013 to March 2014. • The individual had TIVA on 3/17/14. Nursing documented at 12:10 pm that the pulse was 40-50. It was also documented that the anesthesiologist reported that the individual was bradycardic during TIVA. At 1:00 pm, the individual remained lethargic with a heart rate of 42 with respirations of 16. At 2:00 pm, the PCP was notified and ordered an EKG. It was documented that no E KG machine was available at TIVA. The PCP documented in the IPN at 2:50pm was largely that the heart rate was 46. The PCP IPN entry was largely illegible. The individual returned home on 3/18/14. There was no follow-up by the primary care provider of treating dentist. Only two IPN entries were recorded after	

#	Provision	Assessment of Status	Compliance
		3/18/14. The entry dated 3/28/14 documented that labs were done. Another entry on 4/16/14 noted that an emotional assessment was done. There was no review by the PCP to determine the reason for the adverse reaction to anesthesia. There was also no assessment for this individual, who received multiple medications and had a significant medical history, prior to TIVA to ensure that the individual was an appropriate candidate for TIVA. Individual #136 • This individual had a diagnosis of seizure disorder with the last documented seizure in 1982. The last clinic appointment was in 2009. An attempt to obtain an EEG was made in 2013, but was unsuccessful. The individual was, therefore, not seen in neurology clinic. Further attempts to complete an EEG or have follow-up in the neurology clinic were not documented in the IPNs or AMA. • This individual did not have a DEXA scan even though phenobarbital was used long term. • The individual was hospitalized with GI problems on 2/13/14 and returned to the facility on 2/17/14. The PCP wrote a four-line SOAP note that did not include the required components. On 2/18/14, the individual was transferred back to the hospital due to a medication error. On 2/20/14, the PCP made an IPN entry. There was no additional documentation or follow-up. The next PCP entry made on 3/21/14 was documentation of the renal consult. Individual #57 • This individual had nausea and vomiting for 2 days, beginning on 2/1/14. There was no documentation of a physician evaluation, however, a KUB was done on 2/2/14, which showed a possible bowel obstruction. The individual was transferred to an acute care facility where the diagnosis of bowel obstruction was made. Foreign bodies were removed during surgery. The individual returned on 2/12/13 and was seen by the PCP on 2/13/14 (untimed note). Physician evaluations were documented again on 2/16/14 and 2/25/14. • The last EKG was done in 2007 and the individual did not have a DEXA scan even though long term AED use was a significant risk. Individual #242 • This individual had a history of diabetes mellitus and chronic kidney disease. There was no medication prescribed for the diabetes. In April 213, the HbA1c was 6.3. In October 2013, the HbA1c increased to 7.6. There was no intervention for this increase. The individual was not placed on an ADA diet. In April 2014, the HbA1c was noted to be 10.1 at which time the individual was started on an ADA diet.	

#	Provision	Assessment of Status	Compliance
		• The individual was also noted to have a new right bundle brach block on the EKG. An order was written on 3/24/14 to obtain a cardiology consult for evaluation of this new finding. The timeframe was not specified and there was no documentation of the evaluation in the record. This was concerning because a RBBB is associated with several types of structural heart disease and a new finding on an EKG should be evaluated. • There was also no documentation that a colonoscopy was done for colorectal cancer screening. • A June 2012 neurology consult requested that an EEG be completed to evaluate seizure disorder and a CT scan for follow-up of hydrocephalus. There was no documentation that either study was completed. The June 2013 AMA indicated that neurology follow-up was not needed. The same AMA noted that neurology follow-up was needed for evaluation of hydrocephalus. Per the active record, the last neurology appointment was in June 2012. Individual #47 • This individual sustained a scalp laceration on 4/20/14. Nursing documented that the PCP was contacted and an order was given for three staples to be used to close the wound. There was no documentation of how the wound was closed. Specifically, there was no documentation of wound cleansing or the use of local anesthesia. Wound closure with staples should occur utilizing sterile technique. The PCP documented in the IPN on 4/21/14 that the individual fell backwards while walking and sustained a posterior scalp laceration. The entry noted that a 1.5 x 2 cm laceration was closed with three staples. The IPN note did not include any assessment relevant for an individual with a history of falling and sustaining minor head trauma. There was no further documentation by the primary provider. • The irrigation, use of local anesthesia and closure of the wound with staples is not within the scope of nursing practice. The PCP on call should have provided direct treatment or referred the individual to an acute care facility. Individual #313 • This individual had multiple episodes of pneumonia in 2013. The Pneumonia Review Committee notes indicated that the individual's guardian did not want a gastric tube. It was not clear if the guardian was made fully aware of the risks and benefits. The individual has had several episodes of pneumonia in 2014 consistent with aspiration. The AMA completed on 10/10/13 did not list recurrent pneumonia in the assessment and, therefore, the medical supports were not clearly outlined by the primary medical provider. There was no documentation that the primary provider had a discussion with the LAR	

#	Provision	Assessment of Status	Compliance
		regarding the results of the MBSS, which showed aspiration, the recommendation that the individual be NPO and the risk of continued aspiration with oral intake. • The individual had subsequent hospitalizations for pneumonia with chest x-ray, CT scans, and clinical findings being consistent with aspiration pneumonia. The individual was hospitalized on 4/14/14 due to changes in the x-rays and an unclear etiology of the findings. During hospitalization, a bronchoscopy was done which showed large amounts of secretions bilaterally in the bronchi. The individual returned to the facility on 4/22/14. The PCP wrote a post-hospital note on 4/23/14 regarding the hospital course. There was no further documentation by the PCP. The documentation by the PNMT nurse noted that the individual had been on hospice services "until recently," however, the family had decided not to continue hospice. The family had previously refused to allow placement of an enteral tube. These were all very important issues, but the PCP did not address these issues in the post-hospital note. It was unclear what, if any discussion, had occurred between the PCP and the family regarding the status of the individual, the prognosis, and what supports would be provided for the individual. The pharmacy clinical interventions documented many medical care issues. The following are a few examples of problems documented in the pharmacy interventions: • Individual #10, 2/26/14: The last EKG done was completed in 2012 for this individual who received psychotropics. The QT interval on that EKG was prolonged. • Individual #261, 2/24/14: The last EKG was three years ago; the individual received psychotropic medications. • Individual #244, 2/19/14: EKG for monitoring overdue • Individual #140, 2/11/14: VPA level overdue • Individual #336, 2/6/14: Orders were not written for neurology recommendations. • Individual #296, 2/5/14: An order was written on 11/20/13 for a renal consult. The consult remained outstanding. • Individual #47, 1/22/14: The EKG was not reviewed by the PCP. The QT interval was prolonged at 686mS. The PCP was notified and a repeat EKG was recommended. On 1/23/14, the repeat EKG was not completed. The individual received psychotropic medications. • Individual #94: 1/16/13: The orders from the December 2013 neurology clinic were not written; 1/21/14: Medication orders from neurology clinic not written. • Individual #55, 1/9/14: The EKG for monitoring overdue.	

#	Provision	Assessment of Status	Compliance
		• Individual #130, 12/17/13: All labs overdue for this individual who received psychotropics. • Individual #274, 10/11/13: The request to initiate bupropion was started on 9/4/13; as of 12/13/13, bupropion had not been started. • Individual #13, 12/11/13: EKG for monitoring overdue • Individual #257, 12/10/13: EKG for monitoring overdue • Individual #244, 11/26/13: The clonazepam dose was not increased as recommended in the 11/21/13 neurology clinic. • Individual #86, 10/10/13: The order to increase risperidone was not written. • Individual #117, 10/7/13: EKG for monitoring overdue • Individual #4, 9/27/13: EKG for monitoring overdue **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 133 individuals. The following is a summary of AED data submitted by the facility: • 23 of 133 (17%) individuals received 0 AEDs • 55 of 133 (41%) individuals received 1 AED • 19 of 133 (14%) individuals received 2 AEDs • 16 of 133 (18%) individuals received 3 AEDs • 10 of 133 (6%) individuals received 4 AEDs • 4 of 133 (3%) individuals received 5 AEDs The facility submitted data for <u>all neurology appointments</u>. This list included all scheduled appointments. Other lists indicated that several appointments were not completed. The number of individuals with all types of neurological evaluations is summarized in the table below. Neurology Clinic Appointments 2013 -2014 No. of Appointments Oct: 13 Nov: 6 Dec: 9 Jan: 7 Feb: 4 Mar: 2 Total: 41 The 41 <u>completed</u> appointments included on-campus, off-campus, and diagnostic appointments. Diagnostic appointments accounted for 20% of the reported appointments. The epileptologist and general neurologist each conducted a half-day	

#	Provision	Assessment of Status	Compliance
		clinic once a month. On average, there were five neurology appointments completed each month related to seizure management. Per the data reviewed, there was only one neurology clinic held during some months. The facility submitted the contractor's billing invoices rather than submit a list of all individuals seen in the onsite neurology clinics. These invoices documented that neurology clinics were very brief and generally lasted about two and a half hours. Given the number of individuals with seizure disorder, this did not appear to be an adequate number of hours to meet the needs of the individuals and records indicated that individuals did not always have prompt follow-up. As documented above, many individuals required multiple drugs for management of their seizure disorder and management was often complicated. For the 133 individuals, the following represents a summary of key data: • 104 of 133 (78%) individuals with seizure disorder received AEDs • 49 of 133 (36%) individuals received two or more drugs • 14 of 133 (10%) individuals had refractory seizure disorder • 12 of 133 (9%) individuals had a VNS implanted • 0 of 2 (0%) refractory individuals was in the process of a VNS workup • 0 of 133 (0%) individuals had a recent episode of status (within 6 months) The facility reported that no individuals experienced status epilepticus since the last compliance review. The hospital transfer log as well as the neurology consults reviewed documented that Individual #114 was transferred to the hospital with status. The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed above in the documents reviewed section. The following is a summary of the review of the records: • 3 of 10 (30%) individuals were seen at least twice over the past 12 months • 6 of 10 (60%) individuals had documentation of the seizure description • 6 of 10 (60%) individuals had documentation of current medications for seizures and dosages • 5 of 10 (50%) individuals had documentation of recent blood levels of antiepileptic medications • 3 of 10 (30%) individuals had documentation of the presence or absence of side effects. • 7 of 10 (70%) individuals had documentation of recommendations for medications • 0 of 10 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc.	

#	Provision	Assessment of Status	Compliance
		Many of the issues noted in previous compliance reviews were also noted during this review: • Individuals did not always receive prompt follow-up. • Records documented that individuals were experiencing difficulties, such as increasing seizures and the neurologist made recommendations for medication changes or requested diagnostics, such as MRIs or EEGs. However, there was no timeframe specified for follow-up. In some instances, there was no evidence provided that follow-up occurred. • Documentation of medication side effects and even monitoring were not always adequate. Labs were not always available as required and the notes did not comment on side effects of medications. The following are some examples of concerns identified with regards to neurological care provided to the individuals supported by the facility: • Individual #114, who experienced status, was seen in clinic in November 2013. The individual did not have any labs done at the time of the evaluation. The epileptologist recommended follow-up with labs in two months. There was no evidence that this follow-up occurred as of March 2014. • Individual #292 was seen on 10/23/13 for evaluation of intractable seizures. The neurologist noted that the individual had an increase in seizures that was associated with falls and injuries. An EEG was done on 10/15/13, but the results were not available. The epileptologist requested that the EEG be obtained for review and follow-up occur in two months. There was no evidence that the follow-up appointment occurred. • Individual #104 was seen on 11/5/13 for evaluation of intractable seizures. The neurologist noted that an EEG was done, but no results were available. Follow-up in three months was recommended. There was no documentation of a follow-up appointment. • Individual #344 was seen on 4/23/13 with breakthrough seizures. There was no follow-up documented. **Access To Specialists** The facility utilized the state consultation database. It included on-campus and off-campus appointments. It also included diagnostic appointments, such as mammograms and colonoscopies. It was difficult at times to know if an appointment was completed. The data, in several cases, differed from data found in other documents. There was no way to reliably determine if appointments occurred in a timely manner because the date of request and timeframe for the appointments were not known. The monitoring team was concerned about the facility's ability to accurately track clinic and diagnostic	

#	Provision	Assessment of Status	Compliance
		appointments because there was clear evidence in the various documents and records that scheduling appointments for clinics and diagnostics was problematic. This review also surfaced problems with the ability to provide appropriate evaluation for individuals with abnormal EKGs. In one instance, a markedly abnormal QT interval was not noted by the PCP. In another case, a new abnormality was noted, but follow-up with cardiology did not appear prompt. EKGs done by the facility should be "over-read" by a cardiologist. At a minimum, the facility should have the means to have a cardiologist review any questionable routine EKGs within a relatively short timeframe. The facility will need to address the requirement to provide access to specialists as part of the provision of healthcare services. Monitoring of clinic appointments must track the timely completion of appointments based on the determined need and prioritization of the appointment. As noted in the last monitoring report, SASSLC must have a procedure in place to ensure that follow-up of failed appointments occurs in a timely manner. **Acute Care and Hospital Transfers** Problems were identified with the management of acute medical problems. In one instance, a PCP gave orders for nursing to close a scalp wound with staples rather than transfer the individual to an acute care facility. During the daily clinical meeting, the on-call PCP provided a report on an individual who experienced respiratory problems with oxygen saturations in the mid 80s for several hours. The on-call physician did not evaluate the individual or send the individual to an acute care facility for further evaluation and treatment. Upon arrival to the facility, the individual's PCP made the decision to transfer the individual to the emergency department for evaluation. It was reported in the daily clinical meeting that the individual was admitted with pneumonia and respiratory failure. **Do Not Resuscitate** The facility did not submit any documentation related to the DNRs other than a facility-generated chart listing the names of the 15 individuals with active DNRs. This was the same number of individuals reported during the last review. The ages of the individuals were inaccurate by three to four years and several individuals had no qualifying diagnosis listed or stated that the qualifying diagnosis was not applicable. The long term DNRs indicated that the last renewals occurred in 2011. When questioned regarding the facility's compliance with state guidelines and policy, the medical director responded that the state had no policy related to DNRs.	

#	Provision	Assessment of Status	Compliance
		The facility provided no documentation for the justification for the 15 individuals with DNRs. The sole document submitted was the table, which as discussed was incomplete and included outdated information. The lack of information as well as the inaccuracy of information was cited in the last monitoring report. Recommendations were made to address these issues. It appeared that SASSLC did not respond to the concerns of the monitoring team. Therefore, the monitoring team could not further assess this area in order to determine if the 15 DNRs were justified and appropriately implemented. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. All PCPs should be encouraged to attend the ISPS and ISPAs. 2. The medical director must address the requirements for follow-up of acute medical conditions and post-hospital care with the medical staff. 3. The documentation issues discussed in the reported should be addressed. 4. The facility must address the provision of preventive care and cancer screenings. 5. The facility should critically review current data related to pneumonia and hospitalizations associated with bowel issues. Further actions may be warranted following this review. 6. The Pneumonia Review Committee should provide additional feedback and recommendations to the IDTs particularly for individuals with recurrent pneumonia. 7. The medical director must review the current provision of neurological care to determine if adequate services are provided. 8. The medical director should address problems related to access to specialty care. 9. The long-standing issue of DNRs needs to be addressed at this facility.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	<u>Medical Reviews - External</u> An external medical reviewer conducted Round 8 of the medical audits in October 2013. Round 9 was completed the week of the compliance review. State guidelines required that a sample of records be examined for compliance with 46 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. All elements were deemed essential for Round 9.	Noncompliance

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		For Round 8, a total of 27complete and three single diagnosis specific charts were audited. The sample size for Round 9 was not provided. The facility submitted data for the external audits. Those data are summarized in the table below:	

External General Medical Audits Compliance (%)			
		Essential	Non-essential
Round 8	Oct 2013	86	96.5
Round 9	May 2014	92.5	NA

Audits were also completed for select medical conditions. Facility data submitted to the monitoring team is summarized in the table below.

External Medical Management Audits Compliance (%)			
Round 8	Constipation	Seizures	UTI
	100	100	100
Round 9	Diabetes	Osteoporosis	Pneumonia
	87	80	88

There was 100% compliance for the three conditions reviewed in Round 8. However, the exit comments of the reviewer noted that one chart for each condition was reviewed. The sample size for the Round 9, as previously stated, was not provided.

The QA department developed corrective action plans. The status of the plans is presented below.

	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
General Medical Round 8	70	70	0	47	23
Medical Management Round 8	0	0	0	0	0
General Medical Round 9	62	0	62	0	62
Medical Management Round 9	8	0	8	0	8

It appeared that several plans remained outstanding even though Round 8 was completed in October 2013. Documentation was provided indicating that the PCPs were provided feedback on 10/31/13 of the findings of the external audit.

Based on the compliance by question graphs for Round 9, there were a number of areas

#	Provision	Assessment of Status	Compliance
		with less than 80% compliance: • Q#2 - Is there evidence the APL was updated with each new problem? • Q#3 - Is there evidence the APL was updated as problems resolved? • Q#7 - Is documentation present to identify whether the individual uses tobacco products? • Q#19 -Have the appropriate preventive screening for colonoscopies been provided? • Q#26 - Was the PCFS updated at the time of the last AMA? • Q#29 - Did the provider document a rational for not following the recommendations made by the pharmacists if the provider chose not to abide by the recommendations? • Q#33 - Are responses to significant lab values documented in the IPN? • Q#35 - Are significant abnormal diagnostic test addressed by the provider with appropriate timely follow-up documented in the IPN? • Q#40 - If a medical treatment was ordered during an acute illness or injury was it documented in the IPN? • Q#41 - Does the IPN include a SOAP note from a provider within 24 hours of readmission to the SSLC from a hospital? • Q#42 - Did the provider indicate resolution and closure of acute problems in IPN? • Q#45 - Are medical and or surgical consultation recommendations addressed in the IPN within five business days after the consultation recommendations are received? • Q#46 - If consultation recommendations are not implemented is there a clear rationale from the provider in the IPN as to shy they have chosen not to implement the recommendations? The monitoring team inquired about any specific performance improvement initiatives that may have been implemented as a result of the audits. As noted in section L1, the facility had a relatively high incidence of pneumonia. Moreover, as discussed in the mortality management, 75% of deaths were associated with the diagnosis of pneumonia. The monitoring team was informed that there were no specific quality initiatives. <u>Mortality Management at SASSLC</u> There were eight deaths since the last compliance review. The available mortality documents were reviewed. Information for those deaths is summarized below: • The average age of death was 54.8 years with an age range of 29 to 66 years. The causes of death were: o Undetermined	

#	Provision	Assessment of Status	Compliance
		o Aspiration pneumonia, urosepsis o Aspiration pneumonia, sepsis o Respiratory failure, sepsis, pneumonia o Cardiogenic shock, acute myocardial infarction o Pneumonia (3) Data submitted to the monitoring team indicated that the number of deaths each year had increased. There was also a decrease in the mean age at time of death. A summary of the data is presented in the table below.	

Mortality Data 2009 - 2014						
	2009	2010	2011	2012	2013	2014
No. of Deaths	5	7	7	8	9	6
Mean Age at Death	60.6	52.7	57.1	58.5	50.7	58.3
Median Age at Death	62	52	62	60.5	54	62.5

The monitoring team met with the medical director, CNE, QA director, and QA nurse, to discuss mortality management and data. The monitoring team was particularly interested in learning about any further analysis or reviews that were completed by the facility given the eight deaths that occurred over the six months prior to the compliance review. Seventy-five percent of the deaths were related to the diagnosis of pneumonia. It appeared that no formal review or analysis had occurred. The medical director and CNE reported that the number of deaths did result in staff looking at deaths to determine if there were any patterns or trends and none were noted.

Overall, the medical director believed that the mortality review process had been strengthened with the addition of a medical director summary. The external physician reviews continued to be completed by a community volunteer physician. The medical director reported that quarterly mortality reviews were conducted and included trending of internal and external review data. No documentation of the quarterly reviews was provided. The CQI committee minutes included information related to the recommendations generated by the mortality reviews.

<u>Compliance Rating and Recommendations</u>
The monitoring team agrees with the facility's self-rating of noncompliance.
To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration:

1. The corrective actions for Round 8 should be completed.
2. The facility should continue to critically review the mortality data.

#	Provision	Assessment of Status	Compliance
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	<u>The Continuous Medical Quality Improvement Committee</u> Efforts to refine the medical quality program continued. Clinical indicators were revised and at the time of the compliance review included: • ER visits • Hospitalizations • Seizures • Significant weight changes • Pharmacy interventions • Decubitus ulcers • PNMT efficiency • High-risk head injuries The monitoring team attended the meeting held during the week of the compliance review. During that meeting, pressure ulcer data were presented by nursing. The dental director discussed a case of an individual who experienced an adverse reaction during TIVA. A member of the medical staff presented the results of chart audits done on individuals identified as high risk for SIB head injuries. Other data relevant to the clinical indicators were also reviewed. All members of the committee had received basic training on the use of Root Cause Analysis. The focus of the training was the use of the "5 Whys Tool." This approach was utilized in assessing the case of the individual who experienced an adverse reaction during TIVA. During the conduct of the discussion, the committee members became aware that the final root cause using this technique was directly dependent upon accurately defining the problem and/or asking the correct initial question. By focusing on the medication dose increase, staff failed to examine other plausible explanations for the adverse outcome. The use of quality data was discussed with the medical director. Specifically, the committee reviewed hospital data during the March 2014 meeting, which pointed to an increase in the number of admissions associated with bowel issues such as ileus, small bowel obstruction, and constipation. There was no further review of this possible trend. It was clear that that committee needed to continue training related to data analysis and begin to look more critically at the available data. Overall, this process had the potential to be beneficial. The committee will need to continue to add indicators. Structural indicators, such as the ability to provide timely specialty care (clinic data) should be reviewed by the committee. Notably absent from the list of clinical indicators was one that is typically reviewed as part of medical quality programs – key diabetes mellitus metrics. The facility had not conducted any reviews or	Noncompliance

#	Provision	Assessment of Status	Compliance
		audits of this commonly tracked condition in more than six months. Internal Medical Reviews The medical director reported that internal audits were completed in January 2014 and July 2013. State guidelines required completion quarterly, however, the medical director indicated he was not aware that state policy required this. After reviewing the written state guidelines at the request of the monitoring team, the medical director subsequently recalled that QA staff had mentioned that the requirement for internal audits was quarterly. Additionally, following the compliance review, the facility submitted data for internal audits that were completed in October 2013. The data for the January 2014 internal audits, discussed with the medical director, are summarized in the tables below.	

Internal General Medical Audits Compliance (%)			
		Essential	Non-essential
Round 8	Jan 2014	90.75	92.5

Internal Medical Management Audits Compliance (%)			
Round 8	Constipation	Seizures	UTI
	100	100	67

It was reported that the sample used for this audit was the same sample used for the October 2013 external audit. The three month time lapse would make it difficult to use the external and internal audits to assess inter-rater reliability.

The QA Department developed action plans for the deficiencies. Data for those plans are presented in the table below.

Corrective Action Plans					
	Total Action Plans	Reviewed By QA	Remaining to Review by QA	Completed	Remaining to Complete
General Medical Round 8	59	59	0	59	0
Medical Management Round 8	1	1	0	1	0

As noted in the table, all action plans were completed.

Compliance Rating and Recommendations
The monitoring team agrees with the facility's self-rating of noncompliance.
To move in the direction of substantial compliance, the monitoring team offers the

#	Provision	Assessment of Status	Compliance
		following recommendations for consideration: 1. The clinical disciplines should continue to work on development of the metrics that will be used as part of the CQI program 2. The CQI committee members should continue training related to data review and analysis. The medical director should ensure that internal audits are conducted quarterly in accordance with state guidelines.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team requested a copy of the complete medical policy and procedure manual including any other facility policies that were related to medical care. Copies of <u>all clinical guidelines</u> were also requested. The facility submitted the following policies and procedures: • SASSLC Policy and Procedures: o Facility Medical Services Policy, Procedure 200-5A, 3/24/14 o Clinical Death Review, SOP, 300-23 CDR, 3/09 o Minimum Common Elements of Care, 10/14/13 o Continuous Quality Improvement Committee, 4/17/12 o Pneumonia Review Committee, 4/10/12 o Lab Matrix, 9/28/11 • State Supported Living Center Policy and Procedures: o Use of Restraint, Policy No. 001.1, 4/10/12 o Nursing Services, Policy No. 010.3, 6/17/13 o Medication Variances, Policy No. 053, 9/23/11 o Individual Support Plan Process, Policy No. 004.2, 11/21/13 o Incident Management, Policy No. 002.5, 11/5/13 o Serious Event Notification Policy No. 046, 9/1/10 In addition to the policies listed above, a manual including 11 clinical protocols was developed and provided to the medical staff. The protocols and guidelines covered conditions, such as hypertension and seizure disorder. The manual also included guidelines for the metabolic syndrome and a copy of the ATP III Quick Desk Reference. It is important that guidelines reflect the current standards. The manual included the 2001 ATPIII guidelines. The ATP III metabolic syndrome criteria were updated in 2005 in a statement from the American Heart Association (AHA)/National Heart, Lung, and Blood Institute (NHLBI). Updates included the use of medication for control of hypertension and hyperlipidemia as criteria for diagnosis of metabolic syndrome. Nonetheless, it was good to see that the clinical guidelines had been organized into a quick reference source made available to the medical staff. Documentation of inservices related to recent guidelines was submitted. Additionally, the medical director had developed an annual review schedule for the department's policies and procedures. These were all	Noncompliance

#	Provision	Assessment of Status	Compliance
		encouraging findings. Notwithstanding the progress observed in this area, there was still a need for the medical department to develop a comprehensive medical manual that includes the relevant information related to operations of the department and provision of health care services. This would include, but not be limited to, information on staffing and caseloads, on-call coverage and responsibilities, the role of the PCP in the IDT process, requirements for participation in ISPs and ISPAs, and participation of primary providers in various meetings. Procedures related to delivery systems should be provided such as how consults are ordered, the process for obtaining labs, ordering x-rays, and the various tracking systems. The requirements for the actual provision of care should also be included and cover acute care, preventive care requirements, and the expectations for the use of the various clinical guidelines and protocols. This could remain separate with the expansion of the clinical guidelines manual that was developed. Another component of the manual would be the policies and procedures that describe the oversight processes, such as the internal and external medical reviews, the medical quality program, the mortality review process, and the facility's QA system. Other relevant policies, procedures, and guidelines, such as those related to the use of psychotropics, pharmacy services, and other integrated services should also be included. These official documents must include the issue/implementation date and be signed and dated by the appointing authority. Overall, the development of new guidelines and a review schedule along with the documentation that physicians received information on the policies, procedures, and guidelines was evidence of progress in this area. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Develop policies procedures ad guidelines as appropriate. 2. Continue to provide appropriate training and maintain documentation. 3. Ensure that clinical guidelines include the current standards through the annual review process or more frequently when practice standards warrant change.	

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o SASSLC Section M Self-Assessment, updated: 4/17/14 o SASSLC Section M Action Plans, updated: 4/17/14 o SASSLC Section M Presentation Book o SASSLC Nursing Organization Chart o SASSLC Active Record Order and Guidelines o SASSLC Map of Facility o SASSLC Last six months Continuous Quality Improvement Committee Meetings/Agendas, and associated documents o SASSLC Pressure Ulcer Tracking Log o SASSLC Nursing Training Due/Delinquent report, run date: 4/28/14 o SASSLC List of individuals with current IPS dates, Annual/Quarterly Nursing Assessments, IHCPs, ACPs, MOSES/DISCUS o SASSLC Last six months Nurse Managers Agenda/Meeting Minutes o SASSLC Nursing Immunization Tracking Report, (no date) o Mortality Nursing Recommendations Log o SSLC Emergency Response Policy #044.2, effective dated: 9/7/11 o SSLC Emergency Equipment Walkthrough Checklist #044, dated: 9/11 o SSLC AED and Emergency Bag Check Off #044B, dated: 9/11 o SSLC Emergency Oxygen Tank and Suction Machine Check list, #044C, dated: 9/11 o SASSLC last six months, all code blue/emergency drill reports, including recommendations and/or corrective actions plans o SASSLC Last 10 Medication Administration Variances o SASSLC Medication Variance Trend Report o SASSLC Last 10 Medication Inter-Rater Reviews and associated analysis o SASSLC Medication Observation Assignments Due Dates, revised 1/7/14 o SASSLC Last six months Medication Observations Audits, and associated plans of correction o SASSLC Last five months Medication Room Audits o SASSLC Last six months Monthly Medication Inspections o SASSLC Times of Medication Administration o SSLC Medication Variance Policy#053, effective: 9/23/11 o SSLC Medication Variance Report SSLC#053, (no date) o SASSLC “draft” Medication Variance Policy (no date) o SASSLC Medication Variance Committee Minutes, October, November 2013, and February, March 2014 o SASSLC Medication Variance Committee April 2014 Agenda and associated documents o SASSLC Pharmacy and Therapeutic Committee Meeting April2014 Agenda, and associated documents

	○ SASSLC Last five Clinical Morning Report/Notes, ○ dated April 28, 2014 - May 2, 2014 ○ SASSLC Last two weeks of ODRN 24-Hour Reports ○ SASSLC Yellow Flags Committee Agenda/Meeting Minutes and associated documents ○ SASSLC Last six months Pressure Ulcer Tracking Log ○ SASSLC Protocol Cards ○ SASSLC QA/QI Meeting Summaries, September 2013 - January 2014 ○ SASSLC Section M Nursing Monitoring Tool/Protocol Card Compliance Trend Report by Home, January 2014– March 2014 ○ SASSLC Section M Nursing Monitoring Tools/Protocols Audits Trend Analysis by Tool, June 2013 – March 2014 ○ SASSLC Antibiogram ○ SASSLC Last six months of Environment of Care (EOC) Inspections ○ SASSLC Listing of Polices trained to Nursing NEO staff ○ SSLC Nursing Policy: Nursing Services #010.3, effective 6/17/13 ○ SSLC Nursing Guidelines/Protocols/Procedures/Forms • Facility Nursing Coverage Guidelines, revised: 2/3/14 • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13 • Blood Glucose Monitoring, revised: 12/13 • Pretreatment and Post-Sedation Monitoring, revised: 12/13 • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13 • Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14 • Enteral Feeding Record, revised: 11/13 • Medication Observation From, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13 ○ SASSLC List of individuals with gastrostomy, Jejunostomy, J/G tube, tracheostomy, colostomy, ileostomy, Foley catheter and Port-A-Cath ○ SASSLC List of individuals ever diagnosed with human immunodeficiency virus (HIV)

	○ SASSLC list of individuals diagnosed with Methicillin-resistant Staphylococcus aurous (MRSA), Hepatitis, A, B, and C, positive Purified Protein Derivative (PPD), convertors, HINI, Clostridium Difficile (C-Diff) and/or sexually transmitted disease (STD's) ○ SASSLC Last Six Months Infection Control Meeting Minutes ○ SASSLC Infection Control Meeting Agenda and associated documents, dated: 4/29/14 ○ SASSLC Last six months Safety Committee Meeting Minutes ○ SASSLC Last six months Environment of Care Audits ○ SASSLC Last six months Employee Health Data Report ○ SASSLC Targeted Tuberculosis Surveillance: List of individuals with positive PPD, ○ SASSLC List of Individuals diagnosed with hepatitis, A, B, C ○ SASSLC DRAFT Transfers to Medically Enhanced Supervision #300-7A, (no date) ○ SASSLC Last six months Line Listing Individuals Transitioned to Community ○ SSLC Physical Nutritional Management Policy #012.3, effective date: 3/4/13 ○ Records of: Individual #94, Individual #163, Individual #333, Individual #113, Individual #113, Individual #300, Individual #148, Individual #53, Individual #87, Individual #31, Individual #140, Individual #270, Individual #228, Individual #292, Individual #136, Individual #230, Individual #337, Individual #261, Individual #127, Individual #302, Individual #24, Individual #271, Individual #118, Individual #254, Individual #90, Individual #144, Individual #313, Individual #79, Individual #38, Individual #3, Individual #286, Individual #194, Individual #217, Individual #266, Individual #104, Individual #47, Individual #101, Individual #80, Individual #259, Individual #252, Individual #267, Individual #255, Individual #115, Individual #321, Individual #56, Individual #167, Individual #170, Individual #263, Individual #147, Individual #157, Individual #226, Individual #314, Individual #670, Individual #300, Individual #326, Individual #39, and Individual #149 <u>Interviews and Meetings Held</u>: ○ Chief Nurse Executive, Cleveland "Chip" Dunlap, RN, MSN, MHA ○ Nursing Operations Officer, Roseanne Boyd, RN, BSN, MSN ○ Program Compliance Nurse, Robert Zertuche, RN ○ RN Case Manager Supervisor, Jennifer Hall, RN, BSN ○ Hospital Liaison Nurse, Jennifer Costello, RN ○ Infection Control Preventionist, Qiuhua "Ellen" li, RN, Ph.D. ○ Nurse Managers, Shashi Das, RN, MSN, Lola Faulkner RN, Gayhindria Collier, RN ○ Campus Nurse, Elizabeth Francis, RN, BSN ○ Developmental Center Nurse, Amelia Garza-Lester, LVN ○ Quality Assurance Nurse, Mandy Pena, RN ○ PNMT Nurse Patricia Delgado, RN ○ Director of Habilitation, Margaret-Delgado, MA, CCC-SLP ○ Pharmacy Director, Sharon M. Tramonte, PharmD ○ Informal interviews with numerous direct care nurses (LVNs and RNs) and direct support professionals (DSPs)

	Observations Conducted: o Medication Administration Observation various units o Medication Room Inspections on various homes o Enteral Feedings/Stoma Care on various units o Emergency Equipment Inspections on various homes/units o Residential areas at various times of the day (all homes) o Developmental Center Nursing/Workshop Areas o Clinical Services Meetings - 4/28/14, 4/29/14, 4/30/14, and 5/1/14 o Nursing "Yellow Flag" Meeting - 4/28/14 o Nursing Huddles: Morning, Afternoon, and Case Management, - 4/28/14 o Pharmacy and Therapeutics Meeting - 4/28/14 o Infection Control Meeting – 4/29/14 o Nursing Evidence Base Practice Committee Meeting – 4/29/14 o ISP Meeting – 4/30/14 o Nursing Acute Care Plan Meeting - 4/30/14 o Continuous Quality Improvement Committee Meeting - 4/30/14 o Medication Variance Committee Meeting – 4/30/14 o Nursing Schedules Meeting – 5/1/14
	Facility Self-Assessment: The facility submitted its self-assessment and action plans for section M. For each subsection, the facility documented activities engaged in to conduct the self-assessment, results of the assessment, and a self-rating of compliance or noncompliance with a rationale. The facility self-assessment action steps, however, were flawed in a number of ways. Actions steps within the report had completion dates that were earlier than the start date, some items had continued over a two-year span as "in process" without documentation of the progress or lack of progress, and the self-assessment did not look at the same items looked at by the monitoring team. The Nursing Department should include more description about its findings from its data, including the meaning of the data. It should also include inter-rater findings. The facility rated itself as being in compliance M2, M3, M4, and M5. The monitoring team, however, found the facility to be in substantial compliance with one provision: M6.
	Summary of Monitor's Assessment: The CNE established and strengthened standing operational guidelines and expectations for accountability and performance of nursing staff. This led to decrease in overtime and improved communication within the nursing department and other departments. An RN Case Manager was promoted to RN Case Manager

	Supervisor in April 2014. The vacated Nurse Educator position was filled, with an expected start date of 5/15/14. Nursing Audits were improving, but were not consistently trending upward. The Hospital Liaison and facility physician's had obtained access to "real time" hospital records remotely. There was improvement in timely assessments and timely notification to physicians for individual's health care problems, including following their own emergency procedures for emergency health issues. The Nursing Department had been proactive in addressing skin integrity issues through a partnership with external hospital nursing staff that included an exchange of each other's expertise with pressure ulcers. The facility's Infection Control Preventionist was more visible on the homes and had taken lead role in trying to minimize the spread of infections through daily surveillance rounds and attending the morning meetings. However, given the number of infections and cases of pneumonia, the facility should intensify its infection control efforts. The collection and validation of immunization data needed revamping in order to consistently have on day to day basis availability, the immunization/immunity status of individual who reside at SASSLC. Most progress had been made in all aspects of medication administration practice in accordance with generally accepted standards of practice. The facility had improved on tracking and analyzing medication variances, including taking actions that resulted in system changes.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The monitoring team conducted its own independent review of section M through: • Direct observations of selected homes/units/work areas for: o 17 individual's receiving their medications o 23 individuals in their home, work, and leisure environments o performance of nursing assessments and nursing procedures o standard infection control practices o communications/interactions between the individual, DSP, and nurse o inspections of emergency equipment and medication rooms • Formal and informal interviews with 21 nurses • Attendance at facility/nursing meetings • Review of documents, facility self-assessment, action plans, presentation book, and individual record reviews <u>Staffing, Structure and Supervision</u> The CNE is credited in the development of process/procedures to improve upon: • Communication within and between nursing and other departments/team members	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Maintaining consistent staffing patterns • Reduction of overtime • Increased accountability of nursing time and attendance • Recruitment and retention activities The CNE implemented nursing "huddles" that occurred at different times during the day. The monitoring team attended three of these huddles and found agendas for each huddles, observation of communication between nurses, communication of expectations for care and services, interactive nursing communication for improvement ("what is/is not working)." The nursing huddles were seen as being positive and productive. The Nursing Department held weekly Nurse Manager Meetings with detailed minutes for identifying problems and action steps. In February 2014, the CNE began holding Nursing Department Meetings that included nursing leadership. The meeting also integrated other team members, depending on the subject matter being presented. For example, pharmacy for training on aspects of medication safety. Nursing also held weekly Nursing Operational meetings with Nurse Managers, Nurse Educator, NOO, Hospital Liaison, RN Case Manger Supervisor, Infection Control Nurse, QA Nurse, and others as applicable to the subject matter. For example MOSES, and DISCUS discussions included pharmacists. The Nursing Department dispersed a monthly Nursing Newsletter that contained information on new employees, changes in nursing practices, upcoming meetings, and educational requirements. It was evident, during the monitoring team rounds, that the CNE had been effective in creating a positive culture in how nurses responded and interacted with each other, other team members, and their supervisors. The current census provided was 238. The facility data showed, at the time of the review, that 97% of the nursing positions had been filled. The remaining three percent was for a RN Case Manager, RN III, and Nurse Educator. The CNE reported a Nurse Educator had been hired and was expected to begin employment on 5/15/14. Changes that occurred since the last review included: • RN Case Manager Supervisor position vacated, was filled • Campus RN vacated, was filled • RN Nurse Manager Supervisor position vacated, was filled • RN Nurse Manager vacated, was filled • RN Case Manager position was vacated • RN Nurse Educator position was vacated • LVN vacancies were filled In discussion with the CNE, NOO, and Compliance Nurse, the nursing department had strengthened the structure of Nursing Coverage Guidelines, revised 2/3/14, for scheduling,	

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		call-ins, and requirements when reporting for work. The guideline also addressed patterns of tardiness, absenteeism, and progressive corrective actions. The guidelines referred to a deployment guide attachment, but this was not found. The CNE held scheduling meetings to assure staffing ratios were met. However, it could not be discerned from the scheduling documents if an acuity scale was used when determining staffing rations. Since the last review, Nursing reported staffing ratios had not fallen below minimum staffing, and the facility did not use agency nurses to staff. The monitoring team observed, onsite, examples of nurse recruitment and retention activities. Nursing students and their instructor from the LVN program were seen on the units completing their practicums. It was positive to observe the interaction between the CNE and a DSP, who had just completed the LVN nursing program, discussing employment opportunities at the facility. <u>Availability of Pertinent Records</u> A focused review of records on two homes while onsite, found pertinent documents present, however, the review of all records found: • Nursing IPN notes were consistently documented in the SOAP format. • Documentation about the individual's care and services was not consistently legible. For example, Individual #47's IPN notes and Physician Orders, Individual #80's MAR. • Vital signs, and the method for which they were obtained, were not consistently documented. For example, Individual #38. • Omissions (blanks) for recording the individual's bowel and bladder patterns. For example, Individual #104 • Nursing IPNs, when addressing acute injury and illness, and when following up on acute injury and illness, had omissions for the what, when, how, and who for the implementation and follow-up of the interventions. Many instead contained statements of "continue to monitor." The Nursing Department should assure the problems identified are addressed as a part of the nursing peer review activities. <u>Hospitalizations and Hospital Liaison Activities</u> The monitoring team interviewed the Hospital Liaison, and observed her in four of the Morning Meetings held 4/28/14 through 5/1/14 and found: • Detailed reporting regarding the current health status for hospitalized individuals • Hospital Visits were conducted daily • Collaboration among team members, for example physicians and dieticians • When asked, followed-up on and reported the next day on the findings from the	

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		inquires The Hospital Liaison reported she had been performing audits, but due to the number of hospitalizations occurring since November 2013, had not been involved in completing any audits (i.e., as a result of the workload). Additionally, she reported that she was a member, and attended, Pneumonia and Infection Control meetings, ISPAs for post hospitalizations, and CNE morning huddles. The Hospital Liaison reported that she worked Monday through Friday, but that there is a backup nurse assigned for making daily contact on weekends/holidays. For a number of the records reviewed, however, the monitoring team did not find evidence of daily contact to the hospitals. It was positive to find the facility had obtained access to "real time" hospital records for reviewing remotely. The facility had also started holding meetings between the hospital and the facility to address continuity of care issues, for example, a meeting regarding skin integrity that the Hospital Liaison, CNE, and Compliance Officer attended. The monitoring team reviewed four of the most recent hospitalizations for compliance with the facility's Nursing Services and Hospitalization/Discharge/Transfer Policy, Nursing Protocol Card for Emergency/Hospital Transfer, and Hospital Liaison nursing responsibilities for Individual #314, Individual #167, Individual #313, Individual #254, Individual #217 and found: • Three of five records (60%) were found compliant. The remaining two had omissions of including the Hospital Transfer form and ER/LTAC Hospital form (admissions 4/7/14 and 4/10/14), and contained no evidence of documentation of daily contact by the Hospital Liaison or designee during the hospitalizations. At the time of this review, Individual #217 continued to be hospitalized. The monitoring team also reviewed one of the most recent emergency room visits for compliance with the facility's Nursing Services and Hospitalization/Discharge/Transfer Policy, and the Nursing Protocol Card for Emergency/Hospital Transfer for Individual #228 and found the record compliant. The monitoring team noted that the nursing IPNs were improved for these records. When documenting, the baseline data of the acute problem, timely assessments, and other assessments included an appropriate systems review, and timely notification of the physician. The facility should continue progress, and focus on assuring the (P) in the plan does not continue to contain statements of "continue to monitor." In addition to these activities, the monitoring team met with Nursing, PNMT nurse, and the Director of Habilitation to review/discuss how nursing and Habilitation were integrated with regard to hospitalizations. The PNMT nurse reported that she attended the morning	

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		meetings and, for each hospitalization, she conducted a nursing assessment. The monitoring team reviewed Individual #313's hospitalization record of 4/14/14 and found that both the initial PNMT and Nursing IPNs Post Hospitalization Reviews did not include instructions for direct support staff to observe and report. Nursing and PNMT Nurse should continue to foster their efforts of integration to include any process that would eliminate duplication of effort. The PNMT Nurse provided examples of individuals during their hospitalization that had required surgical intervention of a PEG tube for nutrition and hydration. As reported by the PNMT Nurse, these were individuals for whom the hospital intervention for PEG tube placement was not made known to SASSLC until <u>after</u> the procedure was completed. • One example was for Individual #230, admitted in February 2014 for aspiration pneumonia. Prior to the hospital admission, she was eating orally. The monitoring team reviewed the record and found evidence of an integrated IDT process (e.g., change of status meetings, nursing assessments, PNMT reviews, SLP evaluations of oral intake, physician review of recommendations), and trial feedings that led to the individual resuming oral eating and discontinuing her PEG tube in March 2014. This was a positive example of team integration. <u>Infirmary</u> The facility continue to have an assigned bed on home 673 for individuals that required medically enhanced supervision. During rounds by the monitoring team in home 673, the infirmary bed was unoccupied. The NOO reported that the facility continued to follow its "draft" policy for Transfers for Medically Enhanced Supervision for any bed admission. The facility should take the necessary steps to finalize the draft policy (which was in draft format since before the previous onsite review). <u>Assessment and Documentation of Acute Change in Health Status:</u> The monitoring team attended four of the Clinical Morning Meetings. These were attended by nursing, medical, therapies, psychiatry, behavioral health, residential, pharmacy, dental, PNMT Nurse, Hospital Liaison Nurse, CEN, NOO, Infection Control Nurse, and Compliance Nurse. The meeting was chaired by the Medical Director. For each of the meetings, there was an agenda. Each subject was reviewed and a status report was provided. This included any after-hour calls, emergency psychotropic medications, and ODRN 24 hour reports. The Hospital Liaison Nurse provided a detailed report on the status of all individuals hospitalized. It was positive to observe that the Infection Control Preventionist readily provided information about infection control practices. Following the Clinical Morning Meeting, the monitoring team observed the NOO making rounds to provide nursing supervision/guidance to nursing staff for individuals discussed/reviewed in the Clinical Morning Meetings.	

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		During one of the morning meetings, information included a discussion of individuals who were on a "watch list" for weights. However, during the meeting discussion, it was discerned that more work was needed by the facility to create measurable outcomes for individuals who had been placed on, or removed from, the watch list. It should include weight gain/loss occurring within the individual's EDWR. The monitoring team reviewed the Morning Meeting documents for 4/28/14 through 5/2/14, and found that individual cases were considered closed even though nursing had nursing procedures in place that continued to monitor their health status related to the presenting acute illness or injury. The monitoring team reviewed two of the individuals that were reviewed/discussed in the morning meeting, regarding their assessment and documentation of acute changes for Individual #255 and Individual #127 and found. • On 4/29/14, the IPN Nursing note documented, at 7:10 am, that Individual #255 sustained a fall, hitting his head. The Nurse implemented the Nursing Protocol for Head Injury, including vital signs, neurological checks, documentation of the size of the laceration, and notification to the physician at 6:40 am. Orders were received to clean the wound, shave the head around the area, and apply Steri- Strips until further evaluation by his physician. An Acute Care Plan and staff instructions were implemented on 4/29/14. On 4/29/14 at 8:55 am, the individual was evaluated by his primary care physician and sent to the hospital emergency room for "better approximation of wound." Upon return to the facility, on 4/29/24 at 1:00 pm, the staff reported that the individual fell out of the bed at the hospital during a transfer from the bed to his wheelchair. The individual, after returning from the hospital, was re-assessed by nursing, including vital signs, and provided his prescribed pain medication. No documentation was found in the chart that the Pain Scale was implemented, or regarding the effectiveness of the pain medication administered. • On 4/24/14 at 9:15 am, the IPN Nursing Note documented that Individual #127 fell "landing on his hands and knees." The Fall Protocol was not followed. On 4/25/14 at 9:30 pm, staff reported the individual's top lip was swollen and there was bruising to his right arm, at which time neurological checks were implemented. Even though, on the initial assessment, staff reported to the nurse that the individual had not hit his head, the nurse should have prudently implemented the head injury protocol, and conducted a head to toe assessment as outlined in the Fall Protocol. There was no evidence the Pain Protocol was implemented, given the severity of his fall, or that the physician was notified.	

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		Infection Control Since the last review the Infection Control Preventionist (ICP) had obtained membership in a national organization for Infection Control, and was preparing to take the exam to become credentialed by the Board of Infection Control and Epidemiology (CBIC). The monitoring team, on more than one of the homes, observed the Infection Control Preventionist making environmental rounds in the buildings. She was also observed during the Clinical Morning meetings providing information on Standard Precautions and Isolation requirements. It was positive to see the ongoing interaction, and the support of the facility, toward their own infection control program. The CNE ensured the ICP was empowered to perform the necessary surveillance activities, acted up on those activities, and received the necessary information, such as culture reports. The monitoring team suggest to further improve timeliness of information between facility and hospital and enable the ICP to have direct access to "real time" hospital records. The ICP role and functions since the last review were more defined to include the frequency of monitoring. These responsibilities included: • Daily tracking of infection cases/outbreaks or clustering of infections • Monthly provided infection report • Daily real time monitoring of infections • Weekly conducted hand hygiene observations for new/current employees, and during mealtimes • Daily, TB surveillance for new/current employees • Monthly, conducted Environment of Care Inspections (EOC) • Daily, investigate, monitor Sharps injuries, employee injury/exposure • Report to Texas Department of Health, reportable conditions • Collaborate with Texas Department of Health for infectious conditions/diseases/outbreaks • Scheduled and unscheduled provide formal/informal education on infections/isolation/standard/contact precautions • Daily, collected and analyzed data, and present in committees • Attend Environmental Safety Committee, Pneumonia Committee • Chair Infection Control Meeting monthly, and submit minutes • Daily, maintained Lines Listing of individuals diagnosed with Hep B/C, MDROs • Provided listing of Isolates (organisms) from Cultures for producing Antibiograms monthly reports • Advises the facility, Medical Director, on Infection Control Practices and Transmission Prevention The monitoring team attended the facility's Infection Control Meeting, which was well attended by the committee members or their designee. The ICP presented data on the	

#	Provision	Assessment of Status	Compliance
		current infection rates and actions the facility had engaged in to reduce/prevent transmission. The ICP said that the facility used CDC data to define their classifications of infections. The facility documented, in their 4/15/14 minutes, that the urinary tract infections for February 2014 was 11, "bringing the number to the highest since 2013." For soft tissue infections, the facility's data reported that cellulitis accounted for the largest number of soft tissue infections in January 2014 and March 2014. Even though the facility implemented a number of strategies to prevent transmission/reoccurring infections, the monitoring team recommends that, when implementation of routine control measures are not effective, control measures be intensified. The facility should make reducing their overall infection rate a high priority. The monitoring team reviewed Individual #170, Individual #101, and Individual #292 IPNs regarding diagnosed infection and found: • Three of three (100%) of the records included an assessment with vital signs, and appropriate and timely notification to the physician for the individual's signs and symptoms in the initial note. • None of three (0%) initial IPNs referenced the implementation of an Acute Care Plan, or provided, when, how, and what precautions, or specific signs and symptoms of the infection to be reported by the DSP. The facility reported that the occurrence of pneumonias over a 12 month period were 24, reportedly, bacterial pneumonias. The facility had a Pneumonia Committee held by the ICP on a monthly basis. Information included in the document submission documented evidence of a meeting held in December 2013. No other information was available as to the status of the committee and its actions. Facility data of handwashing monitoring during meal time conducted by the ICP showed January 2014, 73%, February 2014, 91%, and March 2014, 86%. The CNE recommended adding other individuals to become monitors because unannounced monitoring may not be producing a "true' measure of how effective the hand hygiene has been. This was because most staff were familiar with the ICP and knew that she was conducting the observations. The CNE planned to develop a new strategy. The facility's Employee Health Nurse LVN provided a line listing of all individuals by home, admission date, and immunity/vaccination status. During the visit, the monitoring team requested the overall percentages of individuals who were current in accordance with CDC recommendations for their vaccinations. The Compliance Officer provided a summary percentage of the numbers from the data submitted by the Employee Health Nurse. The summary numbers included the percentage of individuals vaccinated or claimed immunity	

#	Provision	Assessment of Status	Compliance
		from guardian or had documentation of titers drawn. • Pneumovax, 99.14% • TD/TDAP, 94.04% • Varicella, 99.14% • MMR, 100% • Hep A, 98.72% • Hep B, 100% • Zoster, No percentage was available • Flu, 99.6% • Flu, staff 49.3% The monitoring team, from the data submitted for employee health could not discern compliance for the number/percentage of individuals who were current with their PPDs (skin testing for tuberculosis) and number of convertors. The monitoring team's in-depth review of line item individuals found new admissions for which the immunization status was incomplete. For example, Individual #670 and Individual #326. The facility should ensure that emphasis is placed on assuring documentation of current immunization status. The facility should make concerted efforts to obtain the immunization status as soon as possible in order to determine current adherence to necessary immunizations. The facility should assure that data can be readily retrieved if necessary to determine the current numbers/percentage of individuals/staff who have up to date status. This is essential information for a robust infection control program, and very important should the facility/community have the occurrence of a communicable disease outbreak. The ICP and Medical Director would need immediate access to the most current information. Immunizations/ TB Control/Employee Exposure should be an integral part of the Infection Control Program. (Also see section L of this report.) <u>Quality Assurance Activities</u> The Nursing Department, since the last review, had implemented the following quality assurance initiatives to improve consistency in the documentation of nursing process, nursing protocols, plans of care, and expected standards of care. • Implementation of Yellow Flag System for tracking following-up on acute illness and injuries/applicable acute care plans to resolution • Implementation of Yellow Flag Committee • Development and Implementation of SBAR system • Nurse Focus Monthly Calendar, focusing processes to query nurses' knowledge on Nursing Policies/Procedures/Protocols • Implementation of an Acute Care Plan Committee to review ACPs	

#	Provision	Assessment of Status	Compliance
		• Implementation of Radom Monitoring by type of Tool • Implementation of RN Case Management Trainings • Nursing Evidence Based Practice Meetings In September 2013, the facility began conducting 24-30 Monitoring Tools/Protocol Audits for: • IHCP • Annual/Quarterly Nursing Assessments • Infection Control • Pain Management • SOAP Documentation • Head Injury • Seizure • Constipation Currently, Nursing had systems in place for improvement in the areas of: • Acute Care Plans • Medication Room Audits • 24 hour chart checks • Protocol Cards In addition to the above activities, the facility held a Continuous Quality Improvement Committee (CQI), which the monitoring team attended. One of the positive outcomes from the committee, related to the Nursing Department, was addressing skin integrity issues associated with individuals who become hospitalized. Together, the Hospital Nursing Staff and SASSLC Nursing Department put in place a plan called "Tentative Pressure Ulcer Prevention Plan for Nix Health 2014." The plan included a record review, Pressure Ulcer Assessment and Interventions, and accessible Special Pressure Reduction Mattresses. The plan also addressed ongoing performance improvement activities between the facility and the hospital that included surveillance, co-assessments with Nurses and Educator/Nursing Leadership/Wound Care Center Nurses, and case review for hospital acquired pressure ulcers. The Skin Integrity Meeting had been merged as part of the CQI meeting. During the CQI meeting, the Compliance Officer presented data analysis for the total number of Pressure Ulcers. Since the monitoring team's last review, the facility's monthly database showed that, for both facility and hospital acquired Pressure Ulcers, the ulcers for the eight individuals were resolved. The monitoring team met with the QA Nurse with the presence of the Nursing Compliance Officer. During this discussion, it was positive to find that both the QA Nurse and Compliance Officer, when conducting their audits, reported they provided "on the spot"	

#	Provision	Assessment of Status	Compliance
		education to nursing staff for items that were not compliant. The facility submitted data for audits and for inter-rater audits for January 2014 through March 2014 for infections, pain, seizure, constipation, nursing assessment, acute care plan, and head injury for a total 60 audits. Of the 60 audits, 36 (60%) were found to have inter-rater agreement. The Compliance Officer and QA nurse continued to work closely together to resolve responses to audit questions that had not been in agreement. To improve agreement, the Compliance Nurse and QA Nurse should look at the number of audits and data (items) where there was complete agreement. Nursing and QA should have some ongoing discussions to ascertain if the degree of reliability for some data collected is more critical than other data. The monitoring team attended a Mortality Meeting and also reviewed the Nursing Mortality Recommendations for November 2013 through April 2014. The recommendations log documented nine deaths for which there were 22 recommendations for nursing. Twenty (91%) were documented as completed. Two were pending and had a due date of 5/31/14. One death was pending a review of records and a Mortality Death Review. The CNE and QA Nurse reported a process change for having recommendations include a more proactive approach, meaning as soon as the QA Nurse identified a problem, the Nursing Department acted on the problem (rather than awaiting for the formal Mortality Death Review). The CNE should ensure that the actions steps are doable and measurable. For more on Morality, see section L. <u>Emergency Response</u> Based on a diagram/location/listing of emergency equipment provided by the facility, the monitoring team conducted unannounced inspections on eight of the 11 homes/areas on campus in which individuals were provided supports and found: • Emergency equipment and AEDs, in residences or other areas, in seven of eight observations (88%) were available and in good working order. An emergency equipment required item (suction machine) for the Unit 667 day programming area was not located during the inspection. The NOO, in attendance, immediately put a plan in place to secure a suction machine and posted signs for the location of the equipment. The monitoring team conducted a follow-up inspection on 4/29/14 and found the suction machine to be in place and operational. The monitoring team also queried the DSPs as to the location of the emergency equipment, all of which responded correctly. In addition, the facility took additional positive steps by conducting a Mock Drill on 4/29/14. The mock drill was rated as passed. • Eight of eight nursing staff (100%) were familiar with the use and operation of the emergency equipment. • Based on the monitoring team's observations, the facility did not have visible signs posted throughout campus to indicate where emergency equipment and AEDs were located.	

#	Provision	Assessment of Status	Compliance
		• Seven of eight observations (88%) showed that the facility had located the emergency equipment and AEDs throughout the campus in designated areas, with it stored securely and readily accessible for use. • Seven of eight (88%) reviews of Equipment and AEDs Checklist located in units/buildings showed monthly Emergency Equipment and AED checklists were completed daily for April 2014, by designated nurses, as required. • AED/Emergency Bag/Oxygen Tanks/Temperature log aggregate data for October 2013 through March 2014 had omissions (blanks) for checking the equipment. For example, home 674, October 2013, November 2013, and December 2013; and home 671, December 2013, January 2014, and March 2014. • The facility Nursing Due Delinquent report, dated 3/18/14 showed 100% of nursing staff were current with CPR/BLS requirements. • The facility data showed that, from March 2013 through February 2014, 124 drills had been conducted. Of those 124 drills, 114 (92%) were a scored as "pass." The "failed" scores were associated with the lack of participation of staff during the mock drills. No data were made available for evaluating compliance with the number scheduled against the actual number completed mock drills. • The facility's Emergency Response Policy #044.2, effective 9/7/11, stated that "each home will participate in one drill per month on varied shifts." It was perplexing to the monitoring team that the facility's data showed that no mock drills were conducted on the third shifts. • A review of the facility's policy also stated "all emergency drill checklists will be reviewed at the next daily Incident Management Meeting to ensure follow-up on any identified issues." The monitoring team reviewed the facility's Incident Management Minutes and found none of the minutes referenced the reoccurring problems related to the lack of staff participation. The facility should conduct its own investigation as to the lack of participation of staff during mock drills, and address the performance or lack of performance. The facility rated this provision noncompliant of which the monitoring team was in agreement. 1. Ensure, for the varying degrees of injury and illness, that there are adequate assessments and physician notification, as exampled by the occurrence of falls. 2. Continue efforts to minimize/decrease and prevent the risk of infections. 3. Ensure that immunizations are offered for Zoster, to decrease the incidence of preventable infectious disease, and that information is current on a daily basis 4. Ensure that Infection Control is stressed as an important component of the facility's quality assurance program	

#	Provision	Assessment of Status	Compliance
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	<u>Revised Nursing Assessment Policies/Guidelines/Forms</u> • Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Nursing Assessment • SSLC Standardized Nursing Services Comprehensive Nursing Review Format 9/30/13- updated 1/5/14 The RN Case Manager Supervisor was promoted from an RN Case Manager in March 2014. It was positive, during one of the RN Case Manager meetings, to observe how effective the RN Case Manager Supervisor was in engaging the RN Case Managers. For example, when they raised questions, such as regarding timelines for nursing assessments when individuals have been hospitalized for an extended period of time. The RN Case Manager Supervisor was in the process of obtaining written guidance to ensure they were in compliance with the time sequence for completing their Annual and Quarterly assessments and that they were in compliance with ICF/MR regulations for admissions and discharges. The CNE referred her to staff at SASSLC and the state nursing coordinator to assist with the guidance and documentation. The RN Case Manager Supervisor was in process of organizing systems, refining existing tracking databases for Annual/Quarterly/MOSES/DISCUS, and IHCPs for each nurse, and providing one-on-one training to the RN Case Managers. She was also in the process of hiring an RN Case Manager to fill the vacancy created by her promotion. The RN Case Managers, in addition to having had a change in their supervisor, had experienced changes in the state's nursing assessment guidance and associated forms. The changes occurred in June 2013, September 2013, and January 2014 that required re-training of the RN Case Managers to become familiar with the changes. The monitoring team will follow-up at the next visit for the status of the implemented processes. The monitoring team selected 10 records for reviewing the most recent Admission/Annual/Quarterly Nursing Assessments for: Individual #321, Individual #217, Individual #333, Individual #47, Individual #87, Individual #38, Individual #337, Individual #263, Individual #104, Individual #31 and found: • The overall average for timely completion in accordance with the Admission/ Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment was 93%. • One of one (100%) of the Admission Comprehensive Assessments was completed within 30 days of the admission. • Seven of nine (78%) of the Annual Comprehensive Assessments were completed within 10 days of the ISP meetings. Individual #104 had an omission for submitting the requested accompanying Comprehensive Nursing Review, and Individual #333 had omission for the accompanying Physical Assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Nine of nine (100%) of the Quarterly Nursing Record Review/Quarterly Physical Assessments were completed by the last day of the month that it was due. Of the 10 records, 19 assessments were reviewed for compliance in accordance with current nursing standards and the state's Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment. The review found Admission/Annual nursing assessments compliance was 78%, and quarterly nursing assessments with a compliance score of 76%. Results were attributed to failure to sufficiently summarize individual's response, or other identified nursing problems, to care plans for high/medium risk, state the effectiveness of the plans, and submit the requested records. This resulted in the low overall compliance of the score of 77%. The facility stated they were in compliance with this provision. The monitoring team was not in agreement. 1. The Nursing department should continue to sustain its progress in meeting time lines for all assessments. 2. The monitoring team suggests that the CNE assure there is a process in place for review of a larger sample of all Comprehensive Record Reviews/ Quarterly Assessments/Physical Assessment, and that the RN Case Manager Supervisor has the necessary education/training/supports to conduct those reviews.	
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.	New/Revised Policies/Procedures/Processes/Formats • Guidelines: Care Plan Development, Revised: December 2013 • Care Plan Committee • Yellow Flag Committee Since the last review, the state had developed a bank of interventions for developing nursing care plans. These included human bites, boils, conjunctivitis, dermatitis, contact dermatitis, incontinence, fracture, head injury, laceration, pain, pneumonia and UTI. The Nursing staff reported, even though the applicable care plan may be a standardized model, the focus of the Care Plan Committee was to assure the care plan was individualized. In January 2014, the Nursing Department adopted new templates for the ACPs and updated the ACP audit tool. The monitoring team attended both the Care Plan Committee and Yellow Flag Committee meetings. Yellow Flag Committee meetings were held on the respective unit that had a designated Yellow Flag in order to follow-up on the nursing protocol, the plan of care, and the applicable Acute Care Plan. It was evident that the Nurse Managers were excited about the new processes. This was observed on home 671, where the Nurse Mangers were coaching staff to be more specific in what they were going to monitor (as the monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
		team had suggested). Individual #3''s Acute Care Plan was reviewed using the facility audit tool in the Acute Care Committee meeting. The monitoring team provided technical assistance as requested in reviewing the nursing care plan, specific to goals, and instructions for DSPs. The monitoring team reviewed 15 ACPs that had been recently implemented. Of the 15, eight were for infections, five were for individuals with ACPs for Post Anesthesia Care, one was for skin integrity (laceration), and one for pain for: Individual #56, Individual #252, Individual #228, Individual #136, Individual #115 Individual #170, Individual #313, Individual #292, Individual #302, Individual #87, Individual #38 and Individual #104. Individual #38 had three ACPs and Individual #104 and #228 each had two ACPs. The format was different for the same health condition, but perhaps this was due to the new template the facility was putting into place. • 10 of 15 (67%) had sufficient data to identify the health problem. • 12 of 15 (80%) had goals to adequately identify the desired outcomes of the health issues for which the care plans were designed to resolve. • Nine of 15 (60%) included the frequency of the interventions, what should be documented, who should document, and where to document. • Four of 15 (27%) plans were individualized. • 10 of 15 (67%) included that the DSPs were trained on the DSP instruction sheet. The monitoring team could not discern if all staff on all shifts had been trained, or the dates of the training. • Individual #56, Individual #252, Individual #228, Individual #136, and Individual #115's TIVA/Post Anesthesia ACPs all had the same generic plan. Two of five (40%) plans sufficiently addressed the appropriate interventions that were aligned with the procedure performed. For example, Individual #115, Individual #136, and Individual #56's plans included "SN may apply cold towels for first four hours following extraction; apply to face for 15 minutes of time," but none of these three individuals had a tooth extraction. Since the last review, the state office had revised January 2014 Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Assessment format when completing the Community Living Discharge Planning (CLDP) process. For this review, the monitoring team requested the Nursing Discharge Summaries and their associated packet for the last five community discharges. None of these reviews were applicable to the current revised guidelines format. The monitoring team reviewed discharge reports for Individual #266, Individual #271, Individual #140, Individual #113, and Individual #148, and found the following. The facility reported that a new process was initiated in February 2014 and should be fully reflected in	

#	Provision	Assessment of Status	Compliance
		the next onsite review. For this set of five: • Five of five (100%) packets contained pertinent and up to date information regarding the individual's immunization/immunity status. • Three of five (60%) packets contained the IRRFS and their ratings. Individual #140's IRRF was blank for the risk rating. Individual #148's IRRF was missing. • Two of five (40%) packets contained the DSP instructions for those with high and medium risk. None (0%) of the DSP instructions were written in person center language or easy to understand. None (0%) of the packets contained evidence of training of the Community Home Nursing staff or DSP. • Three of five (60%) packets contained the IHCP in the packet. Individual #140 and Individual #148's IHCP were missing. • Four of five (80%) showed that the Comprehensive Nursing Assessments for clinical indicators were completed for each health item contained on the Nursing Discharge Summaries within 45 days of the discharge. • Five of five (100%) of the Nursing Discharge Summaries were completed for the individual prior to transferring to the community. • Three of five (60%) of the Nursing Discharge Summaries sufficiently described/documented Special Instructions (likes, dislikes, triggers, how I communicate pain, how I take my medications, special precautions). • Individual #148 was determined by the IDT team as high risk for polypharmacy and low risk for fluid imbalance. The IHCP Direct Support instructions for fluid imbalance did not take into consideration the high alert medication of Lithium. For example, the nursing IHCP stated "to notify nursing if lack of urinary output is noted for one day." One of the most important instructions should have included information about salt and water because lithium is chemically similar to sodium. Thus, it would be important to have included what the individual's baseline for intake of fluid and salt consumption and urinary output and instructions for monitoring when providing training to a community provider. • Individual #140 was taking an oral diabetic drug, metformin. It could not be discerned, from the minimal records in the packet, whether or not the individual was controlled on his medication, or what signs and symptoms he had or had not exhibited in response to the medication. The record indicated that he enjoyed eating out, but did not say how he should be supported in the community when making choices to eat out, given his diagnosis of Diabetes. The importance of person centered proactive DSP instructions cannot be stressed enough. For progress to be made regarding this provision, the ACPs should be individualized to meet the individual's needs, with appropriate goals, specific nursing intervention, that include proactive interventions. The facility should continue its Care Plan Committee.	

#	Provision	Assessment of Status	Compliance
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.	Training/Training Records Reviewed The facility, since the last review, continued to assure training was not interrupted due to the vacancy of the Nurse Educator. The Training Due/Delinquent Report for Nursing Run, dated 4/28/14, showed seven nurses were delinquent for the subject matter Medication Administration. However, these were new hires for whom training will be scheduled by the newly hired Nurse Educator, who was reporting for duty on 5/15/14. In addition, the CNE had instituted a monthly date for training for the upcoming month. The RN Case Manager Supervisor and RN Nurse Managers were responsible for ensuring the goal dates were met. The CNE expected Nurses to receive their training, and failure to become compliant with the trainings were to be addressed via performance counseling. The facility data showed, for the first quarter of the year, that 50% of the 26 bedside competencies due in 2014 had been completed. This was much improved in comparison to the last review. Additionally, the facility now had a dedicated classroom for training and training materials that could accommodate more trainees. Information was not made available for the percentage of nurses completing the required Mosby Training. The facility received a number of revised guidelines/policies/ procedures/forms from the state office. The monitoring team could not discern from the training records, how the Nursing Department documented that nurses had been trained or had an acknowledgment statement of the revisions within the guidelines/policies/ procedure. The monitoring team will follow-up at the next visit as to the overall status of all core, bedside required trainings, and policy/procedure acknowledgements for each nurse, in addition to providing an overall status report of the percentages. Revised SSLC Nursing Guidelines/Protocols/Procedures/Forms • Facility Nursing Coverage Guidelines, revised: 2/3/14 • Comprehensive Nursing/Quarterly Nursing Record Review/Quarterly Physical Assessment, revised: 1/14 • Care Plan Development, revised: 12/13 • Seizure Management Guidelines, revised: 12/13 • Enteral Medication Administration, revised: 12/13 • Enteral Nutrition, revised: 12/13 • DIASTAT AcuDial, revised: 12/13 • Blood Glucose Monitoring, revised: 12/13 • Pretreatment and Post-Sedation Monitoring, revised: 12/13 • Nurse Competency Based Training Curriculum: revised 12/13 • Management of Acute Illness and Injury, revised: 12/13 • Management of the Foley or Supra-pubic Catheter, revised: 12/13 • Neurological Assessment, revised: 12/13 • Medication Administration Observation Guidelines, revised: 12/13	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Medication Administration Guidelines, revised: 1/14 • Self-Administration of Medication Skills Assessment, revised: 12/13 • Gastrostomy Tube: Insertion by a Nurse, revised: 12/13 • Enteral Nutrition, revised: 1/14 • Enteral Feeding Record, revised: 11/13 • Medication Observation From, revised: 11/12/13 • Self-Administration of Medication Monthly Data/Progress Note, revised: 12/13 The monitoring team randomly selected five records from a sample of 10 of the facility's Medium and High Risk for each unit/home for Individual #333, Individual #87, Individual #31, Individual #337, Individual #302, Individual #38, Individual #217, Individual #104, Individual #47, and Individual #263. The monitoring team also randomly selected three records for evaluating adherence to the nursing protocols for Individual #87, Individual #47, and Individual #321. • The monitoring team found that nurses were responding promptly to individual's illness/injury, and during an emergent situation, when they were unable to obtain less than three- to five-minute responses, the individual was sent to the Emergency Room. Notwithstanding the positives, the protocols were not being consistently applied. (Also see M3 for ACPs and M5 for IHCPs.) • On 2/13/14 at 8:17 pm, Individual #87 sustained a laceration stated to be six inches in length and one-half inch in depth. The nurse, after two calls to the on call physician on at two different times with no response, acted promptly by not waiting for a return call and sent the individual to the emergency room. The adherence to the initial head injury protocol was not found, due to the missing neurological record for neurological and vital signs. The associated Nursing Protocol for Emergency Hospital Transfers Nursing protocol was followed and the record contained documentation of the transfer record and communication from the hospital to the facility. • Individual #47's record documented, from 1/17/14 through 4/20/14, that she sustained six injuries, all of which were documented as falls. One of six (10%) nursing IPNs consistently followed the falls nursing protocol for an undressed head to toe assessment ASAP when individual can be safely moved. Five of six (83%) IPNs documented head injury protocols were initiated. For each of six occurrences, five of six (83%) had a corresponding Neuro Check sheet. For each of the five determined as head injuries, there was a corresponding Neuro Check sheet. Each of the five Neuro Check sheets were complete with the required documentation. The record was problematic, however, for a head injury sustained on 4/20/14. Regarding notification to the physician, the nurse, by telephonic order, received	

#	Provision	Assessment of Status	Compliance
		orders to perform a procedure. The procedure may not have been within the nurse's scope of practice, considering the level of education/ preparation by the nurse for performing such a procedure and the Nursing Department's policies. The CNE should review the record for adherence to the nurse practice act and scope of duties at SASSLC. • On 4/24/14, at 3:58 pm, an individual came to the nurse's station to report vomiting. The Nursing IPN documented the color. An assessment of the appropriate body systems and vital signs was performed. The individual was administered a medication for upset stomach. The IPN note did not contain historical information of previous episodic event of vomiting, in which he was administered the same medication. Testing was not performed for the presence of blood in the stomach contents (Hemmoccult) was not documented for the two episodic emesis. The facility reported, for its first quarter (January 2014–March 2014), overall percentages as follows: • Seizure Protocol, 63% • Head Injury Protocol, 62% • Pain Management Protocol, 51% • Constipation Protocol, 43% • Infection Control Real Time Monitoring, 83% • SOAP Documentation, 61% The monitoring team requested documents for Individual #56, Individual #252, Individual #228, Individual #136, and Individual #115 for adherence to Post Anesthesia Care Protocol Card, applicable Pretreatment and Post Sedation, and Pain Protocols. The findings were: • None of five (0%) contained all of the documents requested by the monitoring team. For example, Individual #136, had a missing Anesthesia record, and Individual #115 was missing the Medical/Dental Checklist and Anesthesia record. • One of five (20%) records contained documentation that an assessment was conducted and documented as required by the protocol • One of five (20%) records documented the full set of vital signs including SPO2 in accordance with the protocol schedule • Two of two (100%) of five records documented lung sounds, skin color, signs/reports of nausea vomiting • Five of five records (100%) documented observations about the individual's gait/balance /coordination • Five of five (100%) records documented after a react score of eight by the provider, that the individual was accompanied by a licensed nurse to his or her home. • Five of five records (100%) documented a verbal report from RN to the receiving	

#	Provision	Assessment of Status	Compliance
		licensed nurse. • Five of five records (100%) documented an ACP was initiated. • Two of five (40%) contained the Medical/Dental Checklist. None (0%) of the two Medical /Dental Checklist for the RN/LVN Pretreatment Monitoring was complete. For example, Individual #261 did not have a recorded respiratory rage for baseline vital signs. • Four of five records (40%) contained a completed Post Anesthesia Care Vital Sign Flow Sheet. Of the four records, three (75%) documented the vital signs in accordance with the protocol schedule. • Two of five (40%) contained the Medical/Dental Checklist. Of the two, one Medical/Dental Checklist for the RN/LVN Post Sedation Monitoring was completed in accordance with the schedule for Post Sedation Vital Signs. • One of five (20%) documented records information about the status of the individual swallowing or gag reflex. • None (0%) of the records documented, in the first 24 hours, if the individual returned to his/her normal intake and output, or if the individual had urinary output. • Individual #56 's Anesthesia record documented that "pt (patient) didn't get his meds this am and Versed not as effective, but pt very cooperative." Pre-op orders documented specific medications to be administered, the time to be administered, and an order for what medication should be held. The MAR was missing from the record. The Nursing IPN did not document that the Dentist was notified the pre-operative orders were not followed. • The monitoring team found, consistently, that the first pre-operative vital sign obtained was recorded as the baseline pre-op on the Medical/Dental RN/LVN Pre-Operative, and ACP. The Medical/Dental Pre and Post-Operative RN/LVN section did contain a place marker for assessing pupils. • All (100%) of the records, when documenting under the column category for Med/Effect/LOC/Behavior/Mental Status, documented alertness and responsiveness rather than describing how the individual was alert and what he or she was responsive to, such as being alert when calling his or her name. The monitoring team interviewed the RN, who was new and was the attending supervising RN for most of the dental sedations. She was interviewed in the presence of the Compliance Nurse, CNE, and NOO. The RN reported, when she arrives, the individual is already in the dental chair. She explained, in detail, how the nursing protocol that was to be followed for pre sedation and post anesthesia, and what forms the information was to be documented on. In addition, the NOO provided a correspondence document from the Dentist that contained the role of the Dentist and Nurse in following the protocols.	

#	Provision	Assessment of Status	Compliance
		The facility indicated plans to institute the new audit tool for Post Anesthesia Sedation. The monitoring team suggested to the CNE and NOO to conduct "real time" audits, of which they were receptive. The monitoring team will follow-up at the next visit. The CNE should: 1. Assure nurses have been sufficiently trained in assessment, and documentation of individuals for Pre-Sedation and Post-Operative Monitoring. 2. Collaborate with the Dentist/Medical Director to ensure a Pre-Operative Check List is in place to ensure individual orders and other associated documents (consents) are in place as a part of the pre-check. 3. Investigate why systems for checks and balances broke down. For example, the occurrence of the individual that did not receive the pre-operative medications. 4. Ensure as applicable a medication variance form has been completed. 5. Follow-up on the identified problems above. The Nursing Department had made progress in becoming more compliant with training. Even so, training had not sufficiently transferred to practice as identified in this provision and throughout the report. The CNE should continue its positive progress of training activities, and performance audits, nursing supervision of day to day activities, to assure nurses use the nursing protocols to effectively guide care.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The facility presentation stated "the integration of nursing and other disciplines involved in high/medium risk are communicating better to increase the quality of life for our individuals." Although this was good to hear, it was also perplexing because the assignment of low risk does not rule out the possible eruption of serious health conditions. In other words, integration should be included for all levels of risk. The facility, in its efforts to monitor timeliness of Annual Comprehensive Nursing Assessments and IRRFs/IHCPs implemented in January 2014 began submitting the information to data analysis for tracking. The Nursing monitoring of IHCPs for the 1st Quarter January 2014–March 2014 showed an overall average of 69%. The facility provided data on the percentage of IHCPs in place for high/medium risk. The data showed areas where individuals with a medium risk and individuals with a high risk plan greatly differed. For example, individuals with Diabetes with a medium risk had a completion rate of 46%, whereas individuals with a high risk had a completion rate of 100%. No explanation was provided for the relevance of the presentation of the data or its differences.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Training/Inservice Education • The facility data reported that 14 of 14 (100%) RN Case Managers had been trained in the At Risk Process. • The RN Case Manager and QIDP coordinator had started, in January 2014, holding workshops regarding the risk process. • The RN Case Manager had started holding workshop in January 2014 regarding the risk process and method of writing goals, and outcome objectives, of which was targeted for completion was October 2014. The monitoring team reviewed eight of the most recently IRRFs/IHCP Action Plan with their accompanying ISP for Individual #337, Individual #321, Individual #104, Individual #87, Individual #31, Individual #217, Individual #302 and found: • Seven of eight (88%) had an IRRF, IHCP, Action Plan, and ISP. Individual #104's Annual Risk Rating Form for the ISP, dated 4/15/14, was still in draft and did not contain the completed risk levels. • Seven of eight (88%) showed that all relevant disciplines were included in the decision making process when determining the individual's risk rating. • Four of eight (50%) IHCPs were sufficiently integrated among all disciplines. • Two of eight (25%) IHCPs contained statements for preventive interventions to reduce or minimize all of the risk ratings. For example, Individual #337's action plan included minimizing skin integrity issues by having the individual participate in hand hygiene during her daily living activities, and as a measurable service objective. This was a positive example. • Four of eight (50%) IHCPs included the frequency of monitoring for the clinical indicator. For example, Individual #31, even though determined at low risk for constipation, had nursing interventions with daily monitoring of his bowel habits due to his risk of emesis. This was a positive example of proactive intervention by recognizing that there was potential of an eruption of a serious health condition. • Seven of eight (88%) IHCPs were implemented within five days after the ISP meeting. However, due to the format lacking a place holder for dates and titles, it could not always be determined the exact date all staff were trained. • None (0%) of the DSP instructions were written in person center language. Even though it was easy to understand, it also failed to be individualized. The monitoring team attended Individual #337's ISP meeting on 4/30/14. All of the individual's relevant support team members were present. The individual was present during the meeting. The IDT team had a lack of knowledge about the individual's assessments and associated risk ratings. It seemed that the team members had not sufficiently read/reviewed each other's assessments. This was more evident when the monitoring team asked questions about the disagreement between the risk rating and the	

#	Provision	Assessment of Status	Compliance
		discipline's assessment. The individual's PCP was present, and quickly responded that this would need to be clarified between disciplines. The meeting was very lengthy. The facility indicated compliance with this provision, but the monitoring team was not in agreement because improvement was needed in the quality of data used to support the risk ratings. The IRRF guidelines are meant to guide the process of assisting with risk determination. However, for the majority of the IRRFs reviewed, there was more work to be done toward the inclusion of integrating critical thinking of risk factors/ risk levels within the risk groups. The Nursing Department had also recently revised polices/procedures/formats for nursing assessments and care plans, which directly affects the IRRFs and IHCPs. The facility not had enough time, given the new RN Case Manager Supervisor, to assure the changes had sufficiently been put in practice. The CNE should assure: 1. The RN Case Manager Supervisor has the necessary supports to provide critical thinking educational opportunities to sufficiently transfer knowledge about risk factor and risk indicators in developing IHCP's that result in realistic and measurable outcomes. 2. The RN Case Manager Supervisor conducts a sufficiently large sample of IRRFs/IHCPs and their associated assessment, and findings from those reviews are shared with the RN Case Managers for performance improvement.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to	<u>Revised Polices/Procedures/Protocols</u> • Enteral Medication revised December 2013 • Self-Administration of Medications revised December 2013 • Nursing Administration Observation Guidelines revised September 2013 • Medication Administration Guidelines revised September 2013 <u>Training/Education/Inservices</u> • MOSES/DISCUS • Self-Administration Guidelines • Enteral Medication Administration • Root Cause Analysis • Medication Administration Guidelines <u>Medication Administration:</u> The monitoring team selected and conducted 48 unannounced medication observation passes. Sixteen individuals were observed in their home, or own room, receiving their medication during various times of the day and evening across six of the homes for Individual #94, Individual #163, Individual #53, Individual #270, Individual #292,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	this provision in a separate monitoring plan.	Individual #24, Individual #118, Individual #144, Individual #79, Individual #286, Individual #194, Individual #147, Individual #151, Individual #226, Individual #39, and Individual #149. The observations included oral, crushed medications mixed with different mediums, such as applesauce, pudding, and thickened liquids. The monitoring team's observations included looking for "the essential items " from the facility's Medication Observation Pass Form and found: • 16 of 16 individuals (100%) were observed participating or being assisted by the DSP to participate in hand hygiene prior to receiving their medications. • 16 of 16 individuals (100%) were identified using two methods of identification, prior to receiving their medication. • 48 of 48 (100%) of the medications were administered in accordance with nursing standards for administering the accepted standards of eight rights (right individual, right medication, right dose, right route, right time, right reason, right medium, right texture, and right documentation). • 48 of 48 (100%) of the observations, the nurse prior to, during and after followed established infection control standards. • 48 of 48 (100%) of the observations, the nurse engaged the individual and DSP to remind them of the reason for the medications and what side effects to report from the medications. • 48 of 48 (100%) of the observations, individuals were observed for any "cheeking" or "pocketing" of their medications. • 2 of 2 (100%) medication passes for G-Tube were performed correctly to include ensuring the PNMP plan for positioning was followed. • One of one (100%) non-medication pass, for enteral feeding, the nurse followed acceptable standards of practice, and the individual's PNMP plan for positioning. • 3 of 3 (100%) of the SAMs Programs were performed in accordance with the current guidelines. • 8 of 8 nurses performed the techniques of hand hygiene correctly when administering medications. It was also impressive to observe: • The nurse encouraged and offered additional fluids, of their preference, to individuals who did not have fluid restrictions. • The DSP assured only one individual at time came to the medication window to receive their medications. This was a process developed between nursing and residential to assure the right individual received the right medication. <u>Documentation:</u> The monitoring team reviewed 11 individuals' MARS that had received a PRN medication, including Individual #149, Individual #194, and Individual #226.	

#	Provision	Assessment of Status	Compliance
		• 11 of 11 (100%) MARs documented the reason for the PRN medication • 11 of 11 (100%) MAR contained documentation that the medication was effective The monitoring team also reviewed 16 of the above individuals for blanks (omissions) on the MARs. • None (0%) of the MARs contained blanks (omissions) <u>Oversight and Monitoring of Medication Practices by the Monitoring Team:</u> • 100% of Medication Room focused inspections were found in compliance using the facility's Medication Room Audit tool • 100% of the nurses assigned to perform medication passes were trained • 100% of the nurses who were currently administering medications, had passed both the classroom and bedside nursing competencies (the nursing departments operating policy for new nurses, they are not allowed to administer any medications until they have reached classroom and bedside competency) <u>Medication Variance Committee and</u> <u>Pharmacy and Therapeutics Committee Meetings</u>: The monitoring team attended both the Medication Variance and Pharmacy and Therapeutics Meetings. The committee members included nursing, medical, psychiatry, dental, and pharmacy. Nursing was a large group with the NOO, Compliance Officer, and Nurse Mangers in attendance. The meeting began with the CNE presenting a detailed overview of the changes that had been put in place since the last monitoring team review. These included a new reconciliation process, a more refined reporting process, and a new database for all medication variances. The committee addressed such questions about under reporting and/or low reporting, old processes, and new processes. The facility instituted its new reconciliation process 11/1/13. On 2/1/14, the old medication variance process was transitioned out, and a new one was transitioned in to include following the state's directive for compliance for AVATAR Medication Variance reports. On 3/20/14, all medication variances were placed in one database. The data base was programmed to scale down to sub categories. These categories included home, times, nodes, etc. For each area of the medication variances, the respective discipline director provided a synopsis of the medication variances and action steps. The meeting discussions led to the monitoring team's questions regarding reconciliation of medications. The facility reported during the vacancy of a pharmacy position, medications sent by nursing to the pharmacy for reconciliation, were not reconciled by pharmacy. The pharmacy position had been filled there had been an increase in the number of medication variances, and medication reconciliation and reportedly medication reconciliation process had resumed. Medication Variance data were presented at the meeting and included the new database for all facility medication variances. Information was presented in graphs by home, severity, by	

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		discipline, node, by time and day of occurrence, type of variance. The data were aggregated, analyzed and contained action steps. The monitoring team conducted an informal interview to further clarify information provided in the medication variance meeting with regard to medication reconciliation. The pharmacist confirmed that nursing had followed the facility's planned actions for medication reconciliation in submitting to the pharmacy. But because of the pharmacy vacancy, they were no additional actions taken, thus, the number of reconciled or unreconciled medications to date were not discerned. The facility Director should have been contacted to support the continued progress of medication reconciliation made by nursing and pharmacy. For more information on the Pharmacy and Therapeutics Committee and Medication Variances, please see section N8 of this report. <u>Medication Variances</u> The monitoring team, in addition to reviewing medication variances, interviewed three nurses on the homes, regarding when a medication is discovered or committed, what steps are taken. The nursing staff, without hesitation, provided a detailed step by step of, not only the process, but of the importance of conducting an assessment. All of the questions posed were responded to correctly. There was sufficient evidence that nursing staff were aware and had been trained on the current process for reporting, documenting, and following-up on medication variances. The monitoring team reviewed the last 12 medication variances for Individual #300, Individual #127, Individual #90, Individual #217, Individual #259, Individual #267, Individual #149, and Individual #302. Individual #136, and Individual #259 was comprised by two medication variances. The time period for the medication variances were 2/15/14 through 3/5/14. • Of the 12 variances, five were committed by nursing. Two of those five (40%) were for administration of medication. Of the remaining three, one was a transcription error, and two were documentation errors. The transcription variance was not discovered for 11 days. • Five of five of the Nursing variances were documented in the AVATAR system, which provided a print out and contained the identified cause and corrective action taken. The causal relationship of the variances were reported to be that a chart was placed back in the chart bin. The order was not flagged by the prescriber prior to the chart being placed back in the bin. The facility's system for checks and balances (e.g., the 24-hour chart check) should have caught the order. Reportedly, the facility had a CAP for ensuring that 24-hour chart checks are conducted	

#	Provision	Assessment of Status	Compliance
		appropriately. • Five of five (100%) nursing variances documented notification to the physician. • Five of five (100%) nursing variances contained documentation of corrective action, and were completed within five business days in accordance with the facility Nursing operational standards • Four of four (100%) were medication variances involving multiple disciplines, nursing, medical, and pharmacy. Three were nursing and medical. The medication variance involved the omission of an indication, a medication that sounded similar when taking a dose change for a medication, essential element missing from physician orders • For four of four (100%) of the medication variances involving multiple disciplines, there was evidence corrective action was taken and completed within five business days The following were improvements instituted by the Nursing Department and were observed and/or reviewed by the monitoring team: • Medication administration observation passes were in accordance with generally accepted practices with the exception of some prompts, however, these did not negate the validity of the overall compliance findings regarding the essential elements. • Infection control procedures associated with medication administration included all individuals participating and/or being assisted by the DSP in his or her own hand hygiene. • PNMP Plans were observed as being followed. • Aseptic technique was observed as being followed with individuals who received an alternate route (gastric) for their fluids and medications • Weekly Nursing Medication Variance Meetings to review the magnitude medication variances and "near misses," and their corrective action within established timelines of 5 business days. • Implementation of a five step program for managing medication variances that include reconciliation of medications • Examples of lessons learned and fed back into practice, for example, potential error • Implemented checks and balances in reducing the number of unreconciled medications from January 2013 to 325 in September 2013 • Revamped the medication variance system database to include prescribing, dispensing, and administering. • Developed a "draft" Medication variance Policy that follows national standards for medication error reporting and prevention, focusing on medication safety. Practices, pending approval of facility director • Nursing assessments were performed to include vital signs prior to administering a	

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		prescribed PRN medication The monitoring team disagreed with the facility's rating, and found substantial compliance that the facility had systems in place for safely administering medication, monitoring, reporting and tracking potential and actual variances for cause and effect. The monitoring team recommends for the Nursing Department and facility in order to maintain substantial compliance to continue to: 1. Continue to implement methods for ensuring that, where lessons are identified, the necessary changes are put into practice and progress is tracked, for example decrease risk of harm from high-alert medications 2. Continue to reconcile medication information at multiple points in the care process	

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.2: Medical Care, 5/15/13 o SASSLC Self-Assessment for Section N o SASSLC Action Plan Provision N o SASSLC Provision Action Information o SASSLC Organizational Charts o Presentation Book for Section N o SASSLC Pharmacy Services, 3/15/13 o SASSLC Quarterly Drug Regimen Reviews, 6/1/12 o SASSLC Adverse Drug Reactions, 9/1/12 o SASSLC Pharmacy and Therapeutics Committee, 12/1/10 o SASSLC MOSES and DISCUS, 1/28/14 o Pharmacy and Therapeutics Committee Meeting Notes o Medication Variance Review Committee Meeting Minutes, 10/29/13, 12/18/13, 2/10/14, 2/25/14, 2/28/14, 3/7/14, 3/12/14, 3/12/14, 3/19/14 o Polypharmacy Committee Meeting Minutes o Pharmacy Clinical Intervention Report/Notes Extracts o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Anticholinergic burden and laxative use • Clozapine and tachycardia o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #111, Individual #256, Individual #301, Individual #87, Individual #305, Individual #136, Individual #288, Individual #119, Individual #242, Individual #13, Individual #43, Individual #57, Individual #313 Individual #170, Individual #132, o MOSES and/or DISCUS Evaluations for the following individuals: • Individual #79, Individual #92, Individual #305, Individual #106, Individual #145 Individual #53, Individual #67, Individual #268, Individual #282, Individual #138 Individual #129, Individual #108, Individual #12, Individual #141, Individual #166, Individual #292, Individual #277, Individual #13, Individual #330, Individual #43, Individual #41, Individual #127, Individual #158, Individual #88, Individual #327

	Interviews and Meetings Held: o Sharon Tramonte, PharmD, Lead Pharmacist o David Espino, MD, Medical Director o David Bessman, MD, Primary Care Physician o Mandy Pena, RN, QA Nurse o Robert Zertuche, RN, Program Compliance Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Medical Staff Meeting o Medical Continuous Quality Improvement Meeting
	Facility Self-Assessment: SASSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each of the provision items, the lead pharmacist listed the activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. The facility rated itself in substantial compliance with provision items, N2, N3, N4, and N7. For provision items N1, N5, N6 and N8, the facility rated itself in noncompliance. The monitoring team found the facility to be in substantial compliance with N2, N3, N4, N5, and N7. The monitoring team rated provision items N1, N6, and N8 in noncompliance.
	Summary of Monitor's Assessment: Medications for San Antonio SSLC continued to be dispensed at the San Antonio State Hospital (SASH). This presented a unique set of challenges for the facility. There were also staffing changes with the hiring of a new clinical pharmacist. The pharmacy technician who worked at the state hospital resigned in December 2013. SASSLC did not have a pharmacy and, therefore, there was no department head. The long-term clinical pharmacist remained in the role as pharmacy lead. The facility provided documentation of communication between prescribers and pharmacists, but the majority of the documentation occurred retrospectively. While SASH had implemented the Intelligent Alerts, the system of documentation did not clearly identify them in the notes extracts. This was very different from the findings of the October 2013 compliance review when numerous Intelligent Alerts were documented, but rejected by the medical staff.

	The QDRRs were done within the required timeframes and for the most part were adequately completed. The facility developed a Performance Improvement Team to address the barriers related to completion of the MOSES and DISCUS evaluations. This appeared to have a favorable impact on completion of the evaluations. Moreover, the primary providers were also reviewing the completed evaluations. A modified Hartwig severity scale was implemented and a threshold was set to determine when additional reviews of ADRs were required. The threshold was met twice, but the facility had not established a format for completing the reviews. While the number of ADRs increased in April 2013, it was not clear as to exactly who was responsible for the increase in reporting. DUEs were completed as required and the evaluations included the necessary components. The clinical staff must exercise caution in how they use the results of the DUEs. The findings of both DUEs were used to make generalized statements, but these were inconsistent with the medical literature. During the October 2013 review, the medication variance program was described as being in a state of disarray. Overall, there was improvement, but it was somewhat limited. Under the direction of the new CNE, the medication variance system was overhauled from the reporting process to the development of a new database. While it appeared that medication variances decreased, the significance of the decrease was not clear because the facility lost the ability to reconcile medications upon return to the SASH pharmacy. Finally, documentation for the Pharmacy and Therapeutics Committee must be addressed. The purpose of the committee is to provide oversight and take action on issues related to the medication use process. The committee serves in an advisory role with regards to development of policies, safe practices, and other matters. The documentation of the activities of the meetings is important. The monitoring team received agendas and handouts. Agendas were not distinguished from meeting minutes. Minutes should summarize the discussion and document the action steps, responsible parties, and timelines. The monitoring team requested minutes for the March meeting after the compliance review. Documentation for this meeting was limited to an agenda with a series of handouts. The handouts included boxes with narratives. There were no minutes. This was not an appropriate format for this committee. Minutes should be provided in advance of meetings and should be reviewed at the beginning of the meeting and amended as necessary. Members should approve the minutes and approval should be documented.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen	Medication orders for the facility continued to be filled by the pharmacy department of the San Antonio State Hospital. Orders were faxed directly from SASSLC to the hospital. A prospective review was completed for all new orders through the WORx software program. The program checked a number of parameters, such as therapeutic duplication, drug interactions, allergies, and other issues.	Noncompliance

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	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.	The order clarification process was continued. If the missing information was critical, the pharmacist contacted the prescriber by the preferred contact number. The home was also contacted. If the missing information was not critical, the SASH pharmacist wrote an order clarification. The medication was dispensed based on the clarification written. The order was delivered to the medical staff office later that day, specifically to the medical compliance nurse who sorted the orders and gave them to providers at the next daily clinical meeting for review and signature. The monitoring team requested documentation of interactions between pharmacists and prescribers. The facility submitted a single 42-page document that included all prospective and retrospective communications inclusive of pharmacy and clinic interactions that occurred from September 2013 through February 2014. The information was provided in the notes extracts. Data extracted from that report and provided in the self-assessment are presented in the table below. Clinical Interventions 2013 - 2014 | | Sep | Oct | Nov | Dec | Jan | Feb | | No. of Interventions | 89 | 85 | 73 | 126 | 65 | 134 | | Prescriber Contact (%) | 76 | 94 | 87 | 92 | 83 | 75 | | % Interventions Resolved | 42 | 54 | 53 | 57 | 93 | 99 | As noted in the last monitoring report, the notes extracts did not allow the separation of communication related to prospective orders, which is the focus of provision N1. The data as presented in the self-assessment are misleading because the data represented the total number of interventions and not the number of interventions related to prospective communication required for provision N1. The majority of interventions were not prospective in nature. For example, the self-assessment documented 134 interventions in February 2014. The monitoring team found that 70 of 134 (52%) of the interventions were retrospective recommendations related to neurology and psychiatry clinics. There were also entries related to TIVA and other consultations. Retrospective recommendations were made regarding prescribing, lab monitoring, drug dosages, and other medical care issues. Specific examples are discussed in section L1. The prospective comments were usually related to clarification of orders via the order clarification process, and drug interactions. Some Intelligent Alerts were documented as well. SASSLC implemented the Intelligent Alerts in December 2012. At the time of the compliance review, the drugs monitored included carbamazepine, digoxin, levothyroxine, lithium, phenytoin, valproic acid, warfarin, quetiapine, potassium, and phenobarbital. There were relatively few entries labeled as Intelligent Alerts and the number of Intelligent Alerts reported in the self-assessment was not consistent with the number of	

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		entries labeled in the notes extracts as Intelligent Alerts. This was quite different from the October 2013 compliance review. In fact, the monitoring report for that review commented on the significant number of Intelligent Alerts that the medical staff rejected. The monitoring team requested the Intelligent Alerts Report as verification that the IAs was being done. The lead pharmacist stated that the IA Report was not available because it was not possible to print a report limited to the IAs for SASSLC. Thus, the monitoring team was not able to verify that the Intelligent Alerts were done as required because they were not clearly identified in the notes extracts. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The lead pharmacist needs to provide clear documentation that the Intelligent Alerts are done as required. 2. The lead pharmacist should work with SASH and state office to determine how to develop an Intelligent Alert Report for SASSLC. 3. State office should work with SASH to ensure that documentation of prospective interventions is occurring as required.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	Fifteen QDRRs were assessed to determine the compliance rating for this provision item. The documents were evaluated for compliance with the timelines for completion and content. The QDRRs were thorough and commented on many clinically relevant issues. The reviews included a section that listed active medical problems, medication therapy, and the effectiveness of the medications. Comments relative to medication dosing guidelines/high doses, renal adjustments, metabolic risk, and osteoporosis were also found in the reviews. The monitoring of medication use, anticholinergic burden, and benzodiazepine use were discussed as well. Each review included a table listing pertinent lab values and the dates of the studies. As noted in previous reviews, the monitoring team does not recommend the documentation of lab values by exception. Clinical interpretation of lab studies often required lab values, which the pharmacist did not document. This diminished the usefulness of the presentation of the lab values. Moreover, the QDRRs presented routine lab values that were often done four to five years prior to the current QDRR. This added unnecessary information to the evaluations, particularly when exact values are not provided. A chart with one or two years of lab data is more than sufficient. There continued to be errors related to stacking of information. One individual was noted to have untreated iron deficiency anemia and several bullets later had iron deficiency anemia that was treated.	Substantial Compliance

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		Overall, the clinical pharmacists did an adequate job of assessing very complex medication regimens. Some general issues which are worthy of attention include: • Blood pressure ranges should be provided for individuals with hypertension instead of stating blood pressure is "fairly well controlled." • Specific recommendations should be made to obtain BMD when individuals receive long term AEDs • When appropriate, PCPs should be prompted to consider referral to neurology for evaluation of possible AED tapering when individuals are seizure free for more than five years. • The use of medication to control hypertension and hyperlipidemia should be considered as criteria for the metabolic syndrome in accordance with ATP III guidelines. <u>Compliance Rating and Recommendations</u> QDRRs were completed in an adequate and timely manner. The monitoring team agrees with the facility's self-rating of 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 risks associated with the use of new generation antipsychotic medications.	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. For each use, there was a comment related to the indication and the effectiveness of the medication. The use of prn meds is discussed further in section J. <u>Polypharmacy</u> Medication polypharmacy was addressed in every QDRR reviewed. The pharmacist made recommendations for reduction of polypharmacy as warranted. The monitoring team attended the Polypharmacy Oversight Committee meeting during the week of the review. Psychotropic polypharmacy is discussed in detail in section J11. <u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk was stratified as low, medium, or high. The report indicated what signs and symptoms could be seen as a result of the anticholinergic burden. The results of the MOSES and DISCUS evaluations were included and could be cross-referenced. The facility also completed a DUE related to the anticholinergic burden and bowel obstruction. The DUE is discussed is section N7.	Substantial Compliance

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		Monitoring Metabolic and Endocrine Risk The facility monitored individuals for the metabolic risk through the QDRRs. The laboratory matrix included several monitoring parameters, including glucose, HbA1c, weight, lipid panels, and blood pressure. The QDRR reports included a section/statement related to metabolic risk that provided comments on the relevant parameters. The notes extracts and QDRRs included comments when monitoring parameters were not current. The QDRRs frequently noted the absence of abdominal girths. Guidelines for management of metabolic syndrome were developed. The ATP III criteria for diagnosis of metabolic syndrome were utilized. As discussed in section L4, the guidelines were based on the 2001 ATP III guidelines. The ATP III metabolic syndrome criteria were updated in 2005 in a statement from the American Heart Association (AHA)/National Heart, Lung, and Blood Institute (NHLBI). Updates included the use of medication for control of hypertension and hyperlipidemia as criteria for diagnosis of metabolic syndrome. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of substantial compliance. The monitoring team recommends that the facility update the metabolic syndrome guidelines. It is also recommended that the medical staff have further discussion related to the association between anticholinergic burden and bowel management.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the providers' responses to both prospective and retrospective reviews. Prospective Recommendations Prospective recommendations were generated at the time new orders were written. Much of the documentation related to prospective recommendations concerned drug interactions and order clarifications. There were some, but not very many, entries that were identified as Intelligent Alerts in the documents submitted (notes extracts). Thus, the monitoring team could not really assess the response of the providers to interventions related to Intelligent Alerts. Retrospective Recommendations The clinical pharmacists also made formal recommendations during clinics and when completing the QDRRs. The majority of QDRRs indicated that the prescribers accepted the recommendations of the pharmacists. Explanations were provided on the QDRR report when the recommendation was not accepted.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations This provision remains in substantial compliance. In order to maintain substantial compliance, the medical staff should clearly note in the IPN a clinically justifiable explanation when pharmacy recommendations are not accepted. In the case of recommendations related to the QDRRs, a notation on the QDRR is adequate.	
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.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Maintaining compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. While nursing conducted the reviews, the evaluation required review and completion by a physician. A sample of the most recent MOSES and DISCUS evaluations submitted by the facility, in addition to the most recent evaluations included in the active records of the record sample, were reviewed. The findings are summarized below: Thirty-two MOSES evaluations were reviewed for timeliness and completion: • 31 of 32 (97%) evaluations were signed and dated by the prescriber • 22 of 32 (68%) evaluations documented no action necessary • 9 of 32 (28%) evaluations documented other actions taken, such as drug changes and monitoring • 1 of 32 (3%) evaluations did not include a prescriber conclusion Thirty-one DISCUS evaluations were reviewed for timelines and completion: • 29 of 31 (93%) evaluations were signed and dated by the prescriber • 30 of 31 (96%) evaluations indicated the absence of TD • 1 of 31 (3%) evaluations did not include a physician conclusion The facility developed a performance improvement team to address problems associated with completion of the MOSES and DISCUS evaluations. There were two central issues: the implementation of AVATAR and the identification of all individuals who required evaluations.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The facility revised the MOSES and DISCUS policy to address these issues and trained all relevant staff. Audits were conducted on all records for the period of June 2013 – April 2014. The audits showed that 141 of 237 (69.4%) records were in compliance with the requirements to conduct evaluations. Completion of the MOSES and DISCUS was not required for 34 of 237 (14%) individuals. All of the records reviewed had a current MOSES and DISCUS. This was consistent with the findings of the record audits.

The evaluation forms were modified to include a review by the primary care providers. This ensured that primary providers reviewed the evaluations following the final assessment by the psychiatrists. They could agree or disagree with the conclusion of the psychiatrists. More importantly, this additional step ensured timely review of the findings by the PCPs.

<u>Compliance Rating and Recommendations</u>
The monitoring team disagrees with the facility's self-rating of noncompliance and finds this provision to be in substantial compliance. In order to maintain substantial compliance the facility must continue to identify all individuals who require evaluations and complete those evaluations in a timely manner.</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 report adverse drug reactions. In the past, the clinical pharmacist maintained an ADR summary log that included information, such as the suspected drug, reaction, probability score, severity score, P&T report date, and ADR confirmation. This was a helpful tool, but was not submitted in the document request as previously done.

The facility reported the following ADR data:

<table>
<tr><th colspan="8">ADRs 2013 - 2014</th></tr>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>No. of ADRs</td><td>4</td><td>14</td><td>4</td><td>4</td><td>10</td><td>3</td><td>2</td></tr>
</table>

Twelve additional ADRs were reported in April 2014. The lead pharmacist believed that the discussion of ADRs in the daily clinical meetings contributed to the increase in reporting. The current forms did not indicate who initiated the reporting process and the majority of the documents reviewed appeared to be completed by the lead pharmacist. The physicians were signing the finalized version of the forms.

In addition to the recent increase in reporting, the facility also revised the ADR report form to include a modified Hartwig Severity scale. This scale was used to determine when a case required further scrutiny or review. Level 4 was set as the threshold for further analysis. A level 4 ADR was one, which required the individual to have an</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		emergency department evaluation or resulted in hospitalization of the individual. A specific format for that review had not been developed at the time of the compliance review. There were two level 4 ADRs reported in April 2014. Both involved the antibiotic Bactrim and both required the individuals have further evaluation in the emergency department. It appeared that staff was not clear on how to proceed with conducting further reviews of these cases. While progress was seen in the development of a severity scale, additional work was needed in the application of the scale. Moreover, the monitoring team was not clear on the medical staff's role in ADR reporting. The current reporting forms did not identify the staff initiating the report and it is important for that information to be documented. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. The monitoring team offers the following recommendations: 1. The medical director should work with the medical staff and continue to encourage them to report ADRs. 2. The primary providers responsible for the overall management of health care should complete the physician review of the ADR form (with psychiatry if necessary) and sign the form. There should be documentation in the IPN of adverse drug reactions. 3. The facility policy should be revised to include the Hartwig severity scale. 4. The clinical pharmacist should work with the QA department to develop a tool to complete reviews for cases that cross the threshold for review. The tool should focus on the contributory factors such as people, methods, procedures, policies, training, equipment, and environment in order to determine if gaps in systems contributed to the adverse outcome.	
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	The facility maintained a DUE calendar and completed one DUE each quarter. A DUE on anticholinergic burden and laxative use was completed and presented to the Pharmacy and Therapeutics Committee on 12/10/13. The conclusion was stated as " There is no correlation between anticholinergic burden, the diagnosis of bowel obstruction, or laxative use." The recommendation was to continue to monitor bowel health. The DUE made a global statement based on a limited review. The conclusion should have stated that the findings were applicable to the population reviewed. The facility also completed a DUE on Clozaril associated tachycardia which was presented during the Pharmacy and Therapeutics Committee meeting held on 3/25/14. Fifteen	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	individuals who received Clozaril were reviewed. Many individuals had multiple comorbidities and received multiple medications. The study concluded that "no correlation appears to exist between the use of Clozaril and the incidence of tachycardia." The literature is replete with evidence of the correlation between the use of Clozaril and the incidence of tachycardia. In fact, the incidence is consistently documented in numerous studies as approximately 25%. It is very likely that the power of the study was influenced by sample size, confounding medical factors, and perhaps study design. Both DUEs included the objective, methodology, results, conclusion, and recommendations. Caution should be exercised with regards to generalizing the findings of DUEs. SASSLC staff should revisit the basic objectives of performing drug utilization evaluations. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. The monitoring team offers the following recommendations: 1. Facility staff should review the objectives of conducting DUEs. 2. The conclusions and recommendations of both DUEs should be reviewed and clarified with staff.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Medication Variance Committee was required to meet monthly. Since the last compliance review, there had not been regular meetings of the Medication Variance Committee. Documents reviewed indicated that there were several meetings, but most of these meetings appeared to be limited to participation by nursing staff. Some involved the lead pharmacist. Nursing began holding weekly meetings on 2/10/14. The CNE was not clear on the requirements of the committee participants. He reported that the first Medication Variance Committee meeting was held on 4/10/14. This meeting included participation by the medical staff. The facility's self-assessment confirmed that meetings had not been consistent nor had they been multi-disciplinary prior to this date. The monitoring team attended the Medication Variance Committee meeting conducted during the week of the compliance review. This meeting was well attended and included participation by the medical director, dental director, and QA director in addition to the required nursing staff. The meeting was chaired by the CNE. The CNE explained that a new system was implemented for reporting medication variances. When a nurse identified an error, the physician and ODRN were notified. The ODRN completed the medication variance form and reported it at the next CNE huddle.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The nurse manager then had seven days to investigate the error, implement corrective action, enter information into AVATAR, and return the completed form to the CNE. The CNE then entered the data into the new medication variance database. Medication variance data generated from that database and presented during the committee meeting attended by the monitoring team are summarized in the table below.	

Medication Variances 2013 - 2014								
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Discipline								
Nursing	--	--	1	6	3	11	12	6
Pharmacy	--	--	35	8	31	0	1	1
Medical	4	3	0	2	0	7	2	6
Node								
Administration	--	--	0	3	2	0	5	1
Dispensing	--	--	33	8	31	0	0	0
Documentation	5	9	1	0	0	1	7	2
Prescribing	--	--	3	4	1	14	4	8
Transcription	0	0	0	2	0	2	1	2
Total	72	28	38	18	17	18	19	15

The compliance nurse, medical director, dental director and lead pharmacist all provided information relative to their disciplines. The program compliance nurse reported that a number of initiatives were taken that contributed to the decrease in nursing variances with real time training being one important measure. The medical director discussed initiatives targeted to decrease prescribing variances. There were no medication variances associated with the dental department.

The lead pharmacist highlighted the dramatic decrease in pharmacy errors. This decrease directly correlated with the departure of the pharmacy technician. Without a pharmacy technician, medications returned to the SASH pharmacy were not reconciled and robot dispensing errors were also not detected. It was not known how many medications were returned to the hospital. It was reported that there was some degree of real time reconciliation occurring with nursing; however, when asked how many meds were returned to the SASH pharmacy, since January 2014, the response was "we do not know." There did not appear to be any effort made to obtain this information. Thus, the data presented for 2014 were not reliable.

While nursing had made progress in changing the reporting process and developing a new database, the exact impact of the changes was not clear. The inability to detect dispensing errors and adequately reconcile medications left the status of errors unknown.

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must maintain processes for medication reconciliation. 2. Discipline heads should continue to address variances within their departments. There is a continued need for this system to have administrative oversight as evidenced by the failure to address the lack of pharmacy reconciliation.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC client list o Admissions list o Physical Nutritional Management Policy o PNMT Staff list, back-ups, and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNM Data Reports/Monthly Reviews o PNM spreadsheets submitted o PNMT Evaluation template o PNMT Assessment Audit tools o PNMT Meeting documentation submitted o Daily Provider Meeting minutes o Pneumonia Committee meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months and documentation for the following: Individual #106, Individual #188, Individual #277, Individual #56, Individual #226, Individual #313, Individual #171, and Individual #302. o List of individuals with non-foundational skills in PNMPs o PNM spreadsheets o Individuals with PNM Needs o Completed PNMP Compliance Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Annual Refresher curriculum materials related to PNM o Documentation of staff training submitted o Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves o List of individuals requiring positioning assistance associated with swallowing activities o List of individuals who have difficulty swallowing o Summary Lists of Individual Risk Levels o List of Individuals with Poor Oral Hygiene

	○ Individuals with Aspiration or Pneumonia in the Last Six Months ○ Individuals with BMI Less Than 20 ○ Individuals with BMI Greater Than 30 ○ Individuals with Fractures ○ Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months ○ Individuals With Falls Past 6 Months ○ List of Individuals with Chronic Respiratory Infections ○ List of Individuals with Enteral Nutrition ○ Individuals with Chronic Dehydration ○ List of Individuals with Fecal Impaction ○ Individuals Who Require Mealtime Assistance ○ List of Choking Events in the Last 12 Months ○ Individuals with Pressure Ulcers and Skin Breakdown ○ Individuals with Fractures Past 12 Months ○ Individuals who were non-ambulatory or require assisted ambulation ○ APEN Evaluations for Individual #317, Individual #167, Individual #306, Individual #176, Individual #149, Individual #302, Individual #325, Individual #32, Individual #116, and Individual #301. ○ PNMT Assessments and ISPs submitted for Individual #230, Individual #38, Individual #277, Individual #188, and Individual #149. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. ○ PNMP section in Individual Notebooks for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154.

	Interviews and Meetings Held: o Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director o Patricia Delgado, RN o Brenda Burell, RD, LD o Allison Block Trammell, MM, CCC-SLP o Joanna VanHoove, OTR o Edward Harris, PT, DPT o Dr. David Espino o OTAs, PTAs, Hab technicians and PNMPCs o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Program areas o PNMT meeting o ISP Meeting for Individual #90
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado Gaitan, MS, CCC-SLP, Habilitation Therapies Director, was the best to date. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. The current leadership, the PNMT, and the other therapy staff were on track to ensure that progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself in continued substantial compliance with O.1 and the monitoring team concurred. The monitoring team determined that sections O.4 and O.5 were in substantial compliance. While the actions taken demonstrated consistent progress, the monitoring team determined that O.2, O.3, O.6, O.7, and O.8 were not in substantial compliance.
	Summary of Monitor's Assessment: Gains had been made across all sections due to the efforts of a consistent team of therapists and Margaret Delgado-Gaitan's steady leadership. There was a fully dedicated PNMT with the dietitian as the one new

	member. They continued to refine their processes and documentation. The monitoring team observed both a weekly meeting and an ISPA meeting in which they presented their evaluation findings and recommendations to the IDT. The interactions were very good between the two teams, though both needed to clearly identify specific clinical indicators because they co-developed the IHCP. The evaluation was much improved over previous visits, though work was still needed with regard to the analysis. The weekly meeting observed was also much improved. Three physicians actively participated in the meeting. The negative health outcomes noted by the monitoring team during the onsite visit, however, reflected poorly on the facility's ability to quickly recognize key clinical indicators (linked to specific areas of risk) and to fully engage all team members to take all necessary actions in a timely manner. There was a need to take more of an investigative approach to assessment and analysis. Positioning looked much improved, though this was an area that requires ongoing diligence to maintain staff competence and compliance. Mealtimes on three homes that had issues in previous visits were again observed. Homes 673 and 674 were excellent. Staff were efficient in the delivery of the meals, accurate in implementation of the Dining Plans, and interactive with individuals. No errors were observed. The therapists were encouraged to begin to also focus now on ways to promote more independence and participation through serving themselves, some family-style opportunities and a focus on independent eating and oral motor skills, such as closure on a spoon or lip seal on a cup. There continued to significant concerns in home 670. There was a clear lack of leadership and oversight. Unlike the other two homes, there was no Mealtime Coordinator, no home manager present and only two staff assisting and one working the serving line. The PNMPC was present, but responsibility for mealtime success lies with leadership in the homes. The system foundation is in place, but there must be an expectation that all strategies related to PNM will be implemented fully, accurately, and consistently at all times. A focus on the following is indicated over the next six months: • Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. • Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. • Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA. • Consider a recommendation log to readily track completion of action steps. • More consistent use of the ISPA process with clear documentation is encouraged. • Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs. • Clarification of the staff who had successfully completed all competency-based training was needed. • Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of Dining Plans appeared to occur infrequently.

	• Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. • The consistency of monitoring and findings should be reviewed by the PNMT to establish effectiveness of existing supports for individuals referred to the team. • Review consistency of effectiveness monitoring as conducted by the OT/PTs and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements. • Ensure that ISPAs are held to address changes in status and changes in supports and services. There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. • Ensure use of trigger sheets was consistent with the facility guidelines. • Establish protocol related to the completion of assessments, especially related to nutrition evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. • Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. • Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 11 individuals, chosen from a list provided by the facility of individuals identified as being at a medium or high risk for, or experienced, an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have 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. Sample O.2 consisted of five individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of individuals at SASSLC who received enteral nutrition, for whom APENs were submitted. Some of these individuals might also have been included in one of the other two samples.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional 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,	The facility used the state-approved PNM policy that addressed the broad scope of PNM issues outlined below, but also through a combination of other facility policies, guidelines, and procedural documents (At Risk Policy, ISP Policy, QA Policy, CAP Policy, the OT/PT Procedures, and the PNMT Referral Criteria and Guidelines, among others) outlined a complete and comprehensive system of Physical Nutritional Management, and/or were in practice at the time of this review. These collectively included the following elements: • Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); • The annual review process of an individual's PNMP as part of the individual's ISP; • The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; • The roles and responsibilities of the PNMT; • 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 the 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; • A comprehensive PNM monitoring process designed to address all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. • A system of effectiveness monitoring; and • Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <u>Core PNMT Membership</u>: The PNMT at SASSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. Team members included the following, with start dates: • Patricia Delgado, RN (May 2011) • Brenda Burell, RD, LD (February 2014) • Allison Block Trammell, MA, CCC-SLP (November 2010) • Joanna VanHoove, OTR (December 2011) • Edward Harris, PT, DPT (September 2011) This team had one new member since the previous review (RD); this position changed numerous times over the last four years. Back-ups for each position were assigned. <u>Consultation with Medical Providers and IDT Members</u> The current Medical Services Director, David Espino, MD, was listed as the physician consultant to the team. He had attended 17 of the 26 weekly meetings (65%), consistent with the previous review. PCPs for individuals discussed in the weekly meetings attended three of these meetings. This was reduced from the previous review. Dr. Espino (6) and other staff physicians (4) attended and participated in some of the 15 additional PNMT IDT meetings for specific individuals. The physicians did not routinely review and sign the PNMT assessments, though it was noted that in some cases the RN Case Managers did. • For 5 of 5 individuals (100%) for whom evaluations had been completed in the last six months, evidence was provided of efforts by the PNMT to seek participation by medical staff review of assessment or and/or participation in the	

#	Provision	Assessment of Status	Compliance
		analysis of findings. While attendance at the meeting was an excellent method to gain the input of the medical staff, alternate methods to ensure their availability to the PNMT should be established. IDT members, such as the RN Case Managers who served as a key link to the physician, attended 20 of the 26 weekly PNMT meetings (77%), as well as at least 13 of the 15 additional PNMT/IDT meetings. There was also consistent participation by PNMT RN who attended each of the five Pneumonia Committee meetings (100%). These meetings addressed both individual-specific issues and systems issues. Daily medical provider meetings were held and the PNMT RN was present at 100% of these meetings for which minutes were submitted. Medical and IDT staff attended these meetings, serving as an excellent forum to ensure timely communication with other team members related to the individuals served by the PNMT and to identify others who would benefit from these services. • For 23 of 26 PNMT meetings (88%) held from 9/5/13 to 2/27/14, there was evidence of participation by IDT members, including physicians, RNCMs, QIDPs, therapy clinicians DSPs, and BHSs. This was a slight improvement from the previous review. Though IDT members routinely attended PNMT meetings, the PNMT consistently also reviewed their findings in an IDT/ISPA upon completion of the assessment and routinely attended IDT meetings related to individuals they reviewed or who were referred to the PNMT. At least 15 additional IDT meetings were held to review evaluation findings, develop action plans, or to develop a transition plan upon discharge from the PNMT. IDT and PNMT members participated in each of these. This provided significant alternate opportunities for collaboration in assessment, planning, implementation of interventions and actions, follow-up, and monitoring. The PNMT did not act outside of the IDT. During the initial meeting, risks, rationales, and action plans were discussed, and actions were assigned. The PNMT's function was to provide support to the IDT, which included providing education and knowledge through recommendations, evaluation, and treatment. Action plans were the responsibility of the IDT in conjunction with the PNMT. <u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: • 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas.	

#	Provision	Assessment of Status	Compliance
		• 5 of 5 core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Collectively, the five team members had over 117 years of experience in their respective fields and, together, approximately 24 years with individuals with intellectual disabilities. The back-up team members had 85 years of experience in their respective fields and approximately 47 years with individuals with intellectual disabilities. <u>Continuing Education</u> • 5 of 5 PNMT core team members (100%) had completed continuing education directly related to physical and nutritional supports and transferable to the population served within the past six months. Back-up team members were also listed with related continuing education in the last year. A number of relevant courses were attended by team members: • Patricia Delgado, RN (11.25 contact hours in the last six months) • Brenda Burell, RD, LD (40 contact hours in the last six months) • Allison Block Trammell, MA, CCC/SLP (22.25 contact hours in the last six months) • Joanna VanHoove, OTR (60.25 contact hours in the last six months) • Edward Harris, PT, DPT (60.25 contact hours in the last six months) These included the following: • HHSC Nutrition and Food Service Regional Meeting for State Hospitals and State Supported Living Centers • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • The Seating and Mobility Mat Evaluation from A-Z • Don't Fall into the Seating Rut: Common Misuses and Overuses of Different Seating Components • The Science of Mat Evaluations and Wheelchair Prescription: The Simulation • WC Seating for Pressure Ulcer Prevention: Research Updates • Augmentative and Alternative Communication (AAC) for School-Age Children with Intellectual Disabilities: Strategies for Long-Term Intervention • Defensible Documentation for the Seating and Mobility Therapists Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is maintained for all team members, individually and collectively, via cross training. The facility is commended for supporting this critical aspect of PNM supports and services.	

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		PNMT Meetings • Since the last review, the PNMT met at least once for 26 of 26 weeks (100%) from 9/1/13 to 2/28/14 (meeting minutes submitted for that period). The team met an additional one to two times a week for four of those weeks to review findings from assessments or discharge planning with the IDTs for individuals serviced by the PNMT. • Based on review of the minutes, attendance at the weekly meetings by core PNMT members and/or back-ups for the meetings conducted during this period was: o RN: 26/26 (100%) by core member, 0/26 (0%) by back-up, 100% overall. o PT: 26/26 (100%) by core member, 0/26 (0%) by back-up, 100% overall. o OT: 24/26 (92%) by core member, 2/26 (8%) for back-up, 100% overall. o SLP: 22/26 (85%) by core member, 4/26 (15%) for back-up, 100% overall o RD: 25/26 (96%) by core member, 0/26 (0%) for back-up, 96% overall Absences for core team members without a backup were noted only on 11/7/13 for the RD. Attendance was still well above the criterion of 80% for the core team and above the criterion of 90% overall for all disciplines. This was an improvement from the previous review. • Since 9/5/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (d) PNMT actions, (e) follow-up, and (e) outcomes/progress toward established goals and exit criteria were clearly outlined on a consistent basis. The meeting minutes were maintained and included the following elements: • Member attendance • Individual reviewed • Current weight • EDWR • Level of PNMT Involvement • Reason for referral • Discussion • Action Steps and Due Date • Next review date • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies and procedures in place and evidenced in the monthly QA reports. There was a system of corrective action plans (CAPs) when system issues were identified. They addressed the following:	

#	Provision	Assessment of Status	Compliance
		○ Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; ○ Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; ○ Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting); ○ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan); ○ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and ○ 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. Examples of identified system issues addressed included the following: Mealtime Coordinator training, CAPs developed based on findings from PNMP compliance monitoring, trends of incorrect food textures in Home 674, missing adaptive equipment, and positioning. Section O required that the PNMP be reviewed at the individual's annual ISP meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. Also, the PNMP was to be developed with input from the IDT, home staff, medical and nursing staff, and the PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are actually reviewed in O.3 below. The monitoring team determined that the facility continued to be in substantial compliance with this element of section O.	
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	<u>Identification of PNM risk</u> The majority of individuals at SASSLC (96% per document request) were provided a PNMP, thereby, ensuring that, as per the Settlement Agreement, each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") were reported to be provided a current PNMP. Based on lists of individuals with identified PNM concerns, there were individuals who (a) required physical assistance for positioning associated with swallowing: 24 individuals, (b) were dependent on others to eat: 36 individuals, (c) had difficulty swallowing: 204	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	individuals (defined as individuals with altered diet texture due to dysphagia and those who received enteral nutrition), and/or (d) were considered to be at medium or high risk of choking (approximately 153 individuals) or aspiration (approximately 110 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), 100% were listed with a PNMP. There were no choking events requiring abdominal thrusts (Heimlich) documented since the previous review. <u>PNMT Referral Process</u> Per the SASSLC Physical Nutritional Management policy, individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and were not stable and for whom the IDT needed assistance in the development of a plan, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. Levels of PNMT action included discussion, investigation, and/or action. The criteria for referral included the following: PNMT Discussion (discussion, identify trends determine need for further investigation, and document in meeting minutes) • Referral to PNMT from any source • One episode of aspiration pneumonia • Unresolved emesis (more than three episodes in 30 days, not related to viral infection) • MBS study • Choking incident • Hospital visit for bowel obstruction, GI bleed, or other GI issue • Consideration of gastrostomy tube placement • Six or more falls within 60 days • Fracture of a long bone, spine, or hip • Skin integrity • Unplanned body weight loss of 10 or more within 90 days PNMT Investigation (review risk ratings and action plans, meet with IDT, conduct chart review and obtain other relevant information, determine need for PNMT evaluation or discharge case back to IDT) • PNMT determines that additional information would be beneficial in the decision-making process • PNMT has recommendations for the IDT	

#	Provision	Assessment of Status	Compliance
		PNMT Action (Identify assessment needs, conduct evaluation, analyze data, establish recommendations, measurable outcomes and review criterion, meet with IDT to review findings and recommendations and to develop action plan, implement action plans with the IDT. Review progress per criteria) • Two episodes of aspiration pneumonia in one year • Unresolved emesis (more than three episodes in 30 days for any two months of a year, not related to viral infection) • Two Stage II decubitus ulcers in 12 months • Delayed healing of a decubitus ulcer • Any Stage III or IV decubitus ulcer • Two or more choking incidents in one year • Two hospital visits in six months related to respiratory concerns • Two non-aspiration pneumonia episodes in six months • Two hospital visits for bowel obstruction in one year • Two hospital visits for dehydration in six months • New gastrostomy tube placement PNMT tracking for PNM-related concerns included aspiration pneumonia, emesis, decubitus, falls, fractures, choking incidents, individuals monitored for weight loss, and hospital visits. This was intended to permit them to determine when and if an individual met any of the above criteria, in case this was not recognized by the IDT for referral. There were six individuals listed on the current active caseload for the PNMT (Individual #300, Individual #230, Individual #38, Individual #277, Individual #56, and Individual #149), though Individual #38 and Individual #149 were not listed as referred. Discharge criteria were established via the assessment and at the time they were met, transition from the PNMT to the IDT was planned, including monitoring and re-referral criteria. Individuals in Sample O.1 were reviewed for incidence of the concerns identified as requiring PNMT referral since September 2013. Individuals were generally appropriately reviewed by the PNMT based on the criteria included in the facility policy, as well as other criteria indicating significant PNM needs. There was no evidence in any of the ISPAs that the IDT identified a need to make a referral. Though not formally referred, most individuals who presented with PNM issues were identified via the episode log and reviewed by the PNMT in a timely manner. One exception was Individual #254, who had six falls in 60 days, as of 10/23/13, with no evidence of review by the PNMT until he had a fracture, with falls occurring on 12/27/13 or 12/31/13 (neither of which were listed in the falls list submitted in document XII.18j. By that time, he had at least 18 falls since 9/9/13 and four associated injuries. It was of serious concern that there was no evidence in the PNMT minutes of referral (or self-referral) to the IDT for assessment or	

#	Provision	Assessment of Status	Compliance
		investigation at the time he had met criteria of six falls in 60 days in October 2013. In all cases, there was no evidence of an ISPA related to the reason for referral to the PNMT. In most cases, the referrals appeared to be PNMT self-initiated based on presentation of issues identified in the established criteria. It was noted that the PNMT RN and other PNMT members attended ISPA meetings to discuss individual health status. In a case not included in the Sample 0.1, it was noted that though Individual #47 was eventually reviewed by the PNMT, it was initially documented that there was no need for PNMT involvement because she had not experienced serious injuries (10/3/13). The falls list submitted reported that she had 13 falls from 9/11/13 through 12/5/13, with injuries associated with three of these. This was of particular concern given the lack of review for Individual #254 (described above). She again appeared in the PNMT incident log on 11/14/14 for falls. The data reported by the PNMT reflected 19 falls in September 2013 through that time in November 2013. There was no discussion of the incidence of injury or any actions to be taken by the PNMT and no rationale for this documented. On 11/21/13, evidence of PNMT review appeared in the meeting minutes. After additional falls in November 2013, her status with the PNMT was changed from discussion to investigative on 12/5/13. There was further evidence of review on 12/12/13, 12/19/13, 1/9/14, and 1/16/14, when it was determined she would be reviewed on 3/20/14 with no clear rationale for this course. In two other cases, there was no evidence that the PNMT reviewed them in any manner. These were the (1) Individual #104 who met criteria for falls on 12 16/13, with seven falls through 12/5/13, and three with associated injuries, and (2) Individual #147 who met criteria for falls on 10/27/13, with 9 falls through 1/3/14, and three with injuries. There were two individuals listed who had received enteral tube placements since the previous review (Individual #230, Individual #38). • 0 of 2 (0%) of individuals who received a feeding tube since the last review had been referred to the PNMT prior to the placement of the tube. • 1 of 2 (50%) individuals who received a feeding tube placement since the last review had been referred to the PNMT after the tube placement. There was no evidence of review by the PNMT for Individual #230 (tube placement on 2/19/14). It was noted, however, that in the case of Individual #230, she was ultimately referred to the PNMT (on 3/7/14), and an assessment was completed on 3/28/14. It was not clear why her hospitalization and tube placement had not been discussed in previous PNMT meeting minutes. The team had discussed the status of Individual #38 as of 2/25/14, the date of her referral and two days following her discharge from the hospital. Her tube was placed during a hospitalization on 2/21/14. None of these were planned, but it was not clear if	

#	Provision	Assessment of Status	Compliance
		they were placed on an emergency basis. PNMT Assessment The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status, with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Assessments completed in the last six months included the following: Individual #230 (3/28/14), Individual #38 (3/19/14), Individual #277 (no completion date), Individual #188 (1/23/14), and Individual #149 (3/5/14). • 3 of 5 PNMT assessments (60%) were initiated at a minimum within five working days of the referral, per the dates in the assessment, meeting minutes, and IPN documentation. This was an improvement from 0% in the previous review. • 5 of 5 PNMT assessments (100%) were completed in 30 days or less of the date of referral, per the assessment dates (the signatures were not dated by any clinician). This was an improvement from 0% in the previous review. Based on review of these assessments, the following elements were addressed (individual #s in parentheses refer to those assessments that did not contain that element): • Date of referral by the IDT or self-referral and the referral source (5 of 5, 100%). The referral source was not identified. This was consistent with the previous review. • Date the assessment was initiated (3 of 5, 60%) (Individual #188 and Individual #277). This was a decrease from 100% in the previous review. • Evidence of review and analysis of the individual's medical history (5 of 5, 100%). This was consistent with the previous review. • Identification of the individual's current risk rating(s), including the current rationale (5 of 5, 100%). This was consistent with the previous review. • Recommended risk ratings based on the PNMT's assessment and analysis of relevant data. (3 of 5, 60%) (Individual #277 and Individual #230). This was consistent with the previous review. It may be implied that the PNMT agreed with the most current risk assessment, but this was not clearly stated. This was a decrease from 100% in the previous review. • Discussion of the impact of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition (5 of 5, 100%). This was consistent with the previous review. • Assessment of current physical status (5 of 5, 100%). This was consistent with the previous review. • Information about the individual's current respiratory status based on a physical assessment (5 of 5, 100%). This was consistent with the previous review. • Assessment of musculoskeletal status (5 of 5, 100%). This was limited, however.	

#	Provision	Assessment of Status	Compliance
		This was consistent with the previous review. • Evaluation of skin integrity (5 of 5, 100%). This was an improvement from 33% in the previous review. • Evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning (5 of 5, 100%). This was consistent with the previous review. • Positioning that may impact PNM status including during bathing, medication administration, and oral hygiene based on observations of these activities (5 of 5, 100%). This was an improvement from the previous review. • Evaluation of motor skills (5 of 5, 100%), though limited. This was consistent with the previous review. • List of medications with potential side effects listed with individual allergies. This generally addressed drug/drug or drug/nutrient interactions and/or actual side effects (5 of 5, 100%). This was consistent with the previous review. • Evidence of review/analysis of medication history over the last year and current medications, such as dosages, and side effects (5 of 5, 100%). This was consistent with the previous review. • Evidence of review/analysis of lab work (0 of 5, 0%). This was consistent with the previous review. There were a few references to findings related to medication review by pharmacy and some references in the IDT risk ratings, but none related to nutritional health or other health indicators as reviewed by PNMT core team members. • Identified residual thresholds, if enterally nourished (1 of 4, 25%). • Tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation (5 of 5, 100%). This was consistent with the previous review. • Evidence of observation of the individual's supports at their home and/or day/work programs (5 of 5, 100%). This was consistent with the previous review. • Nutritional assessment was adequate (0 of 5, 0%). Evaluation of nutritional status and needs was very limited and inadequate. This portion of the assessment was generally limited to a weight history, a list of physician orders, and the current diet order. Nutritional status and dietary needs were not addressed. The dietitian only signed two of the assessments and in one case it was stated that her signature was not required. The dietitian was a core team member and should be expected to participate throughout the entire process. If there are no nutritional concerns for an individual, this should be clearly stated based on a full nutritional assessment and analysis. This was consistent with the previous review. • Evaluation of current assistive equipment (5 of 5, 100%). This was consistent	

#	Provision	Assessment of Status	Compliance
		with the previous review. • Evidence that the PNMT conducted hands-on assessment (5 of 5, 100%). This was consistent with the previous review. • Identified the potential causes of the individual's physical and nutritional management problems (5 of 5, 100%). This was consistent with the previous review. • Identified physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations (5 of 5, 100%). This was often not addressed in the analysis, but rather recommendations were listed without a clear justification in the analysis section. In some cases, recommendations were listed in the analysis section. In the assessment for Individual #277, the analysis was somewhat improved, however, the recommendations justified in the analysis were not included in the recommendations. Other recommendations, not addressed in the analysis were then listed in the recommendations section. This was consistent with the previous review. • Recommendations for measurable skill acquisition programs, as appropriate (0 of 5, 0%). • Evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP) (5 of 5, 100%). This was consistent with the previous review. • Recommendations for monitoring, tracking or follow-up by the PNMT (0 of 5, 0%). This was a decrease from 100% in the previous review. There was no delineation of monitoring responsibilities by the PNMT in the assessment, but was outlined in the IHCP attached to assessments for Individual #188, Individual #149, and Individual #277. • Discussion as to whether existing supports were effective or appropriate (5 of 5, 100%). Monitoring data and effectiveness data previously gathered by the IDT were not consistently reported. • Establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status (0 of 5, 100%). This was a decrease from the previous review. Some were generally established as triggers in the original risk review by the IDT, but these were not specifically addressed by the PNMT. This is not the same as criteria for discharge. • Measurable outcomes related to baseline clinical indicators, including, but not limited to when nursing staff should contact the PNMT (0 of 5, 0%). This was a decrease from the previous review. The outcomes listed appeared to be limited to PNMT discharge criteria. • Signatures of all core team members (or alternate) with dates (0 of 5, 0%). In each case, there were one or more core team members that did not sign the	

#	Provision	Assessment of Status	Compliance
		assessment report. This was a decrease from 33% in the previous review. Other findings included: • There were improvements noted across two of the elements. • There were decreases across seven areas. • Others remained consistent with the previous review, though one of these was 0% as it pertained to nutritional assessments. • 100% of the assessments contained 21/31 (68%) of the applicable elements. • Seven elements were lacking or inadequately addressed for all of the assessments reviewed. Specific Concerns noted included: • As discussed during the PNMT meeting held for Individual #59, objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. These should be integrated into the IHCPs and IRRFs. Key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. These will not likely be the same objectives for re-assessment or discharge from the PNMT. • The analysis continued to improve, but was inconsistent as to content and format. It is still recommended that the team establish guiding questions to ensure that the content for this section is consistent. There were a number of recommendations that did not have a clearly stated rationale in the analysis. It should analyze pertinent data, identify the basic underlying causes of the issues that resulted in referral, and clearly establish the rationale for recommendations, actions and supports required. These should be clearly linked to an aspect of the analysis. The PNMT may want to review the outline for the communication and OT/PT assessments to get some ideas on how to proceed with this. • The PNMT should establish measurable outcomes as indicators of improved health as they provide supports, criteria for discharge, criteria for review, and criteria for re-referral. As stated above, the clinical indicators established for IDT monitoring may not be the same as for re-referral. The team should consider whether it is acceptable, for example, that an individual be re-referred for a repeat aspiration pneumonia, but perhaps sooner when the clinical indicators established indicate that there was a change in status. Antecedents should be identified to alert care providers to take specific actions. • The legend in the weight history chart stated that OW indicated an overweight condition with BMI less than 18.5. This is inaccurate. • The nutritional assessments were weak in this (and in the previous) review. This	

#	Provision	Assessment of Status	Compliance
		was also noted of the PNMT evaluation for Individual #59, discussed during the onsite visit. It is critical that this be adequately addressed. • IHCPs were often vague and did not specify actions. For example, in the case of Individual #59, action steps included: 1. Implement pleasure feeding to return to least restrictive practice. 2. PCP to review/rewrite medication change orders to reduce anticholinergic burden. 3. Neurology consult to determine neurologic status. 4. Increase enteral feeding slowly to maintain stomach volume toleration. None of these provided adequate detail for implementation by the IDT and certainly not as a document record of the outcomes and recommendation related to PNMT supports and services to this individual. The objective data sections had improved, with the exception of the nutritional assessment sections. It continued to be evident that much work was being done, but the documentation still did not highlight this effectively, in particular the analysis, recommendations, and action plans. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were five assessments submitted as completed by the PNMT since the previous review: Individual #230 (3/28/14), Individual #38 (3/19/14), Individual #277 (no completion date), Individual #188 (1/23/14), and Individual #149 (3/5/14). Individual records for these individuals were requested. Plans contained in the individual records resulting from PNMT recommendations included the following components: • In 2 of 5 (40%) individual plans reviewed, identified PNM needs as presented in the PNMT assessment were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. • For 1 of 2 (50%) individuals for whom HOBE assessments were conducted, the recommendations were integrated into the individual plans. • For 2 of 5 (40%) individuals, there were appropriate, functional, and measurable objectives outlined to allow the PNMT to measure the individual's progress and efficacy of the IHCP and PNMP. As described above, these appeared to be discharge criteria. • In 2 of 5 (40%) individual plans reviewed, there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 0 of 5 (0%) individual plans reviewed, the specific clinical indicators of health status to be monitored were included. • 2 of 5 (40%) individual plans defined triggers. • 2 of 5 (40%) individual plans identified the frequency of monitoring.	

#	Provision	Assessment of Status	Compliance
		Completion dates for action steps were not documented in the IHCPs reviewed. <u>PNMT Follow-up and Problem Resolution</u> Each of the recommendations identified in the PNMT assessment should be clearly and consistently tracked through to completion with timely implementation. This could not be adequately determined due to the extreme volume of documentation that was not specific to the individual. The revised documentation system should result in reduced paper, making review (by anyone) more effective. The PNMT may want to consider the development of a recommendation log in order to track its own timeliness. • For 100% of individuals, implementation of individual action plans was within 14 days of development of the plan or sooner as needed for health or safety. • For --% individuals (NA), action plan steps had been generally completed within established timeframes. This could not be determined based on the IHCPs submitted because the completion dates were not documented. Intervals of PNMT review were clearly stated, and these appeared to occur on a timely basis, though again this was difficult to track. IPNs were consistently entered by the PNMT, and generally reflected actions taken, outcomes, and dates of completion consistent with the meeting minutes. All of this needed to be more well integrated into the ISP process, as discussed above. <u>Individuals Discharged from the PNMT</u> Discharge was noted for the following individuals: Individual #106, Individual #188, Individual #277, Individual #56, Individual #226, Individual #313, Individual #171, and Individual #302. • A discharge summary provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP for 3 of 9 individuals (33%). o A progress note was written for Individual #277 regarding his discharge on 10/17/13, though he was later re-referred related to a change in status in December 2013. An IPN was also written to document the discharge for Individual #302. The PNMT evaluation for Individual #188 also served as his discharge summary. Though a PNMT Individual Case Review was completed for the other individuals, one did not specify that the individual was to be discharged (Individual #171) and none were filed in the records. The discharge summary should be written as a detailed IPN and filed chronologically. In the case that a separate discharge summary was needed and filed elsewhere, there should be an	

#	Provision	Assessment of Status	Compliance
		IPN that references the discharge and date of the summary. • There was evidence of ISPA/ISP documentation and/or action plan for discharge of 5 of 8 (63%) individuals (Individual #56, Individual #171, Individual #188, and Individual #106, and Individual #302), though these did not consistently include clinical indicators to track health status and criteria for referral back to the PNMT. There was generally documentation of a PNMT meeting with a signature sheet signed by both the PNMT and IDT, but these were not filed as an ISPA. As stated in previous reports, an effective PNM program requires that the referral to the PNMT occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is urgency to complete PNMT assessments. Even so, some interventions may need to be implemented immediately, before the written report is finalized. It is critical that the assessments be completed in a timely manner. At this time, the SASSLC PNMT appeared to understand this responsibility. It was of concern, however, that the PNMT did not take action sooner, based on documentation review, related to individuals who experienced incidents, such as falls, as described in regard to Individual #47 and Individual #39. Following the onsite review, however, the facility reported that these two individuals were reviewed regularly at PNMT and their interventions regarding falls more appropriately delegated to the IDT. The facility self-rated this provision in substantial compliance, but the monitoring team did not concur. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that all recommendations and actions identified in the PNMT assessments are adequately documented in the ISPs, ISPAs, IRRFs, and IHCPs. 2. Ensure that the PNMT assessments address the essential elements outlined above and that the information is presented clearly and succinctly. 3. Ensure that assessment, discharge and other key elements of support from PNMT service are reflected in an ISPA. 4. Consider a recommendation log to readily track completion of action steps.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or	<u>Identification of Individuals Requiring a PNMP</u> As described above, 100% of the individuals with identified PNM needs were provided a PNMP at SASSLC. The Settlement Agreement (in O.1, but reviewed here) requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual ISP meeting. Teams are also required to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend.	Noncompliance

#	Provision	Assessment of Status	Compliance
	nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	Review of the PNMP and Dining Plans is required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT/speech and the PNMT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the PNMT, OT, PT, and/or SLP clinicians. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. For individuals in Sample O.1, ISP attendance and pre-ISP documentation related to required attendance were reviewed. The most current ISP for Individual #149 was not available in her record, so a zero was scored for each of these. Pre-ISP required attendance sheets were submitted for nine and/or required attendance was identified on the sign-in sheet for 14 of 17 individuals. • For 16 of 17 individuals (94%), the appropriate disciplines were present at the ISP meeting to approve and integrate the PNMP into the ISP. There were one or more Habilitation Therapies representatives at each meeting and. due to the current team assignments and routine clinical services meetings, when issues and coverage for ISPs were reviewed weekly, this was an adequate approach. • For 10 of 14 individuals for whom pre-ISP required attendance sheets were submitted (71%), the designated team members were present for the ISP meeting per the sign-in sheet (Individual #226). Team members designated to attend but not present most often included: Home Manager/Supervisor (4), DSP (8), the individual (5), day program/vocational (2), and OT (2). In the case of the OT, another Habilitation Therapies representative was present at both meetings. A dietitian attended only 3 of the 17 ISPs, though designated to attend only one of these. In other cases, the dietitian was marked as not available, that information was provided by the RN case manager, or not designated as required to attend. It appeared that the dietitian was needed at a number of these meetings, but had not been designated to attend. This professional is a key team member, particularly as it related to PNM concerns. Regarding PNMP review: • 14 of 17 PNMPs (82%) indicated some level of review by the individual's IDT in the annual ISP meeting. The reviews documented in the ISPs varied significantly in specificity and thoroughness and not all clearly identified what changes were required and efficacy of the plan. Only one specified the frequency of monitoring needed (Individual #349). • For 5 of 5 individuals in Sample O.1 for whom the IDT identified changes needed to be made to the PNMP in the interim of the annual ISP, revisions based on the IDT discussion were documented in an ISPA. These did not include a clear rationale, plan, or timeline for implementation. Though clear timeframes for completion were not stated, they were usually made that day or within 48 hours.	

#	Provision	Assessment of Status	Compliance
		PNMP Format and Content Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 17 of 17 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 17 of 17 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 13 of 17 PNMPs (76%), there were large and clear photographs with instructions. The others were generally independent. This was an improvement from 70% in the previous review. • 17 of 17 PNMPs (100%) identified the assistive equipment required by the individual with rationale and purpose. This was consistent with the previous review. • In 10 of 10 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair. This was an improvement from 92% in the previous review. • In 17 of 17 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. This was an improvement from 85% in the previous review. • In 17 of 17 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous review. • In 17 of 17 PNMPs (100%), bathing instructions were provided. This was an improvement from 65% in the previous review. • In 17 of 17 (100%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 90% in the previous review. • In 17 of 17 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. This was consistent with the previous review. • In 17 of 17 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 17 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 7 of 17 individuals had feeding tubes with no oral intake. 7 of 7 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was consistent with the previous review. • In 17 of 17 dining plans (100%), position for meals or enteral nutrition was	

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		provided via photographs, and the pictures were large enough to show sufficient detail. This was consistent with the previous review. • In 9 of 10 PNMPs/dining plans (90%) for individuals who ate orally, diet orders for food texture were included. The exception was Individual #142. Diet texture was listed as solid. All foods are solids, but the specific texture of the food should be specified. This was a decrease from 100% from the previous review. • In 10 of 10 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was consistent with the previous review. • In 17 of 17 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular dining utensils. This was consistent with the previous review. • In 17 of 17 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. This was consistent with the previous review. • In 17 of 17 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was consistent with the previous review. • 16 of 17 PNMPs (94%) included information related to communication (how individual communicated and how staff should communicate with individual). This was a decrease from 100% in the previous review. The PNMPs continued to be very good, with continued comprehensive content in most areas. • 100% of the PNMPs reviewed contained at least 95% of the essential elements. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> There were at least seven individuals with a documented change in status included in Sample 0.1 (Individual #38, Individual #230, Individual #188, Individual #149, Individual #254, Individual #142, Individual #313, Individual #277, and Individual #233) • For 5 of 8 individuals with a change in status, or 63%, ISPA meeting documentation noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status other than PNMT assessment findings (Individual #142, Individual #230, Individual #254, Individual #313, and Individual #38). • For individuals for whom the PNMP was revised, there was supporting documentation that 100% of the revised PNMPs had been implemented. The changes were made, in most cases, that day or within 48 hours. Other non-critical changes were made in less than 30 days.	

#	Provision	Assessment of Status	Compliance
		The monitoring team concurred that the facility was not in substantial compliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. More consistent use of the ISPA process with clear documentation is encouraged. 2. Documentation of required changes to the PNMP should be clearly and consistently evident in the ISPs and ISPAs.	
04	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were generally readily available in the dining areas and PNMPs were included in the individual notebook. General practice guidelines (foundational training) were taught in NEO and in individual-specific training by the therapists, PNMPCs, and residential staff. Based on observations conducted by the monitoring team: • 93% of dining plans were implemented as written for at least 30 individuals observed (errors noted for Individual #332 and Individual #235). • 97% of PNMPs for approximately 40 individuals related to positioning and mobility were implemented as written, or alignment and support were consistent with generally accepted standards (error noted for Individual #343). Based on additional observations: • 100% of six transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. • (NA) individuals' oral hygiene plans were implemented appropriately or consistent with the PNMP. No oral hygiene was observed during this review, so this metric was not rated. • In 100% of observations of medication administration for 16 individuals by the monitoring team, the SSLC nurse followed procedures in the PNMP. The facility implemented Mealtime Coordinator (MTC) training consistent with the statewide plan. A Mealtime Coordinator was seen in most of the homes with the exception of 670. This was the home where mealtime errors were noted. Standardization of this process is essential to ensure adequate competency of these key staff. Unit directors need to be intimately involved in implementation and oversight of the program. 8 of 10 (80%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan. These questions pertained to rationale for assistive equipment, areas of risk and triggers, rationale for food textures and liquid	Substantial Compliance

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		consistencies, transfers, and positioning. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • Staff are assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. • Staff should review plans just prior to implementation of strategies, particularly at mealtime and, as such, information should be fresh on their minds. The monitoring team determined that the facility was in substantial compliance with this provision. The facility should ensure that the Mealtime Coordinator position is fully implemented across all homes for all meals. Observations related to oral hygiene will be conducted during the next review.	
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.	<u>NEO Orientation</u> SASSLC had a system of comprehensive competency-based training regarding PNM services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of PNMPs. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Based on the schedule submitted, class time included approximately 16 hours to address lifting and Physical Nutritional Management. The topics, based on review of the curriculum materials, were comprehensive. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. New employees were given very limited time to practice new skills, but were required to take a combination of written tests and checked off on specific skills. Return demonstration was required for each skill. Employees were expected to pass all essential elements of the core competencies. The legitimacy of competency testing was likely limited given the timeframe permitted. Check-off stations were established by the PNMPCs for additional check-offs. Shadowing was then conducted prior to new employees being permitted to work independently on their assigned homes. They were not assigned a caseload, but were	Substantial Compliance

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		allowed to assist existing staff in the implementation of foundational skills in that home. During that time, staff were to receive on-the-job trained related to the PNMPs and Dining Plans on the assigned home, as well as on individual-specific (non-foundational skills) competencies, generally by the PNMPCs. • 113 of 113 staff (10%) completed NEO core PNM training (i.e., foundational skills) based on the participation reports. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs was submitted. A six-hour refresher training had been developed in the area of dysphagia and lifting/transfers. This also included a number of the competency check-offs used in the NEO training described above. Again, the training contained good content, though the time available for instruction and practice was very limited. • 159/159 (100%) of staff required to take the Annual Refresher class related to PNM successfully passed the competency check-offs. • There was a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. There were four individuals identified with non-foundational components related to their PNMPs. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized PNMP strategies prior to the provision of services. • Per the system, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their communication plans (i.e., non-foundational skills) prior to the provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency.	

#	Provision	Assessment of Status	Compliance
		The facility self-rated noncompliance with this provision, however, the monitoring team determined that substantial compliance was obtained based on the findings above. Still: 1. Clarification of the staff who had successfully completed all competency-based training was needed.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> <u>Monitoring System</u> The facility implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. Further, PT was responsible to monitor individuals for the current PNMP and whether it was followed by staff. OT was responsible for monitoring individuals for the current Dining Plan and whether it was followed by staff. The standardized system for compliance monitoring of the PNMPs and Dining Plans consisted of a determination of frequency outlined in the OT/PT assessment based on a flow chart related to risk levels. This was generally conducted by the PNMPCs and clinicians in conjunction with effectiveness monitoring. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP. • There were sufficient instructional guidelines for those using the forms to monitor. • All monitors (PNMPCs) and therapy clinicians were competent to monitor the PNMP elements based on the training submitted. Per the current assessments submitted, frequency for the individuals in Sample O.1 was as follows: <u>PNMP Monitoring</u> • Three times per month: Individual #254, Individual #38, and Individual #277 • Monthly: Individual #142, Individual #259, and Individual #226 • Eight times per year: Individual #233, Individual #199, Individual #124, and Individual #230 • Six times a year: Individual #25 • Quarterly: Individual #313 and Individual #154 • Bi-annually: Individual #349 (This frequency was of concern to the monitoring team because he was identified at high risk for aspiration, was enterally nourished, and was not recommended for mealtime monitoring). • There was no recommendation for PNMP monitoring for Individual #56, though he was identified with a PNMP for enteral nutrition and this would be expected. • There was no recommendation for PNMP monitoring for Individual #188. His PNMP was related to dining only because he was independent in other areas and	Noncompliance

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		had no special need for physical management supports. • There was no current assessment for Individual #149 as described above in O.1. <u>Mealtime Monitoring</u> • Three times per month: Individual #277 • Six times per year: Individual #25, Individual #254, Individual #38, and Individual #230 • Eight times per year: Individual #124 • Ten times a year: Individual #313 • Quarterly: Individual #233, Individual #154, and Individual #142 • Bi-annually: Individual #188 • There was no recommendation for mealtime monitoring for Individual #56, Individual #199, Individual #226, Individual #349, and Individual #259, though they were identified with Dining Plans/PNMPs related to enteral nutrition and this would be expected. • There was no current assessment for Individual #149 as described above in O.1. The forms submitted were reviewed to determine if monitoring was completed as per the established schedule and if all areas of the PNMP had been reviewed, across all shifts within that time frame. Findings were as follows: • PNMP Monitoring was not conducted at the established frequency described in the assessments for 7 of 17 individuals. As stated above, there was no current assessment for Individual #149, but she was monitored in January 2014 and in March 2014. The other six individuals were Individual #124, Individual #254, Individual #38, Individual #154, Individual #142, and Individual #277. • This could not be determined for Individual #56 because there was no recommendation for monitoring though this was indicated. PNMP monitoring was conducted over the previous quarter. • While collectively, monitoring occurred across all three shifts, this was not the case for each individual. Overall, approximately 60% of the PNMP monitoring occurred on first shift, 27% on second shift and 9% on third shift. • Medication administration was not monitored for any individual in the sample and did not appear on the (very complex) monitoring form. • Across 44 monitoring forms completed for 17 individuals, only two involved bathing, one for oral hygiene, one for medication administration and two for mealtime. • It was noted, however, that the PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase	

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		other PNM risk, including: o Meals o Bed positioning o Wheelchair positioning o Medication administration o Oral care o Bathing o Transfers • Mealtime Monitoring was not conducted at the established frequency described in the assessments for 8 of 17 individuals. As stated above, there was no current assessment for Individual #149, though she was monitored in January and in February 2014. The other seven individuals were Individual #124, Individual #254, Individual #38, Individual #154, Individual #233, Individual #25, and Individual #277. o This could not be determined for Individual #56 because there was no recommendation for monitoring. Mealtime monitoring was not conducted over the previous quarter, though he was enterally nourished. PNMP monitoring was conducted, but not during a tube feeding. o While collectively, monitoring occurred across all meals, this was not the case for each individual. Overall, approximately 27% of the mealtime monitoring occurred at breakfast, 55% at lunch, 14% at dinner, and 5% during a snack (10:05 pm for Individual #38). o Five individuals were not recommended for mealtime monitoring because they were enterally nourished (Individual #199, Individual #226, Individual #349, Individual #56, and Individual #259). No mealtime monitoring was conducted for any of these individuals. Only in the case of Individual #199 did any PNMP monitoring occur during a meal (1/23/14), assumed to be enteral nutrition as he was NPO. No other PNMP monitoring appeared to be conducted during a tube feeding for any of the other individuals. This was of significant concern to the monitoring team because each was identified as high risk for aspiration. o Individual #277 was recommended for mealtime monitoring three times per month, yet there was no evidence that this had been conducted even once over a three-month period. He also had only been monitored related to his PNMP on only one occasion (1/7/14), though this had also been recommended three times per month. This was of significant concern because he was at high risk for aspiration. This element was self-rated to not be in substantial compliance and the monitoring team concurred. While there was an established system of compliance and effectiveness monitoring, compliance with the recommended frequency appeared inconsistent based	

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		on the sample reviewed. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of the Dining Plan appeared to occur infrequently. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency. 3. The consistency of monitoring and findings should be reviewed by the PNMT to establish effectiveness of existing supports for individuals referred to the team.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>Monitoring by the IDT and/or PNMT to Assess individual Progress and Plan Effectiveness</u> There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency was not reported as a recommendation in the annual assessments or the PNMT evaluations. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale • IHCPs generally contained indicators identified to assess the individual's PNM status. • Based on the sample of individuals selected for O.1, evidence of effectiveness monitoring for each was requested for the last six months. This was provided for January 2014 to March 2014 only, for 13 of the 17 individuals in Sample O.1. The compliance monitoring form included a section that addressed effectiveness monitoring and both were conducted in conjunction by the OT and/or PT. Only six forms addressed the effectiveness of the Dining Plan: Individual #230 (2), Individual #313 (3), and Individual #142 (1). All others were related to the PNMP, though two of these occurred during a tube feeding (Individual #199 and Individual #226) and another during a meal (Individual #313). • For at least 1 of 6 individuals with Aspiration Trigger Sheets, there was evidence that the IDT identified the need for, and developed, individualized triggers. • Trigger sheets for 6 of 6 individuals were generally completed correctly (100%), with very few blanks, though the systems used varied across shifts and individual staff.	Noncompliance

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		• Trigger sheets for 6 of 6 individuals were reviewed at least daily by the nurse, though instructions were for review every shift. Though many were reviewed on multiple shifts, there were numerous blanks in the documentation suggesting that a shift nurse had not reviewed the data. The monitoring team concurred that the facility was not in compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review consistency of effectiveness monitoring as conducted by the OT/PTs and the PNMT to ensure that the frequency is as recommended and that the guidelines are followed as to this process to address each of the necessary elements. 2. Ensure that ISPAs are held to address changes in status and changes in supports and services. There should be a determination in every ISPA as to whether the PNMP, IRRF, and or IHCP need to be modified based on the identified issues and plans outlined. If no changes were necessary, this should be stated to demonstrate that this was considered. 3. Ensure use of trigger sheets was consistent with the facility guidelines.	
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.	<u>Evaluation of Individuals who Received Enteral Nutrition</u> • The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals that identified 51 individuals who received enteral nutrition. Individual #59 was identified in other documentation that she had a tube placed in March 2014 and was not included in the list submitted, for a total of 22% of the current census. Thirty-four individuals were listed with gastrostomy tubes and 16 with PEG tubes. Thirty-three received intermittent feedings, 12 received continuous feedings, and four received bolus feedings, per the list submitted. Individual #38 was identified as only using the tube as needed for meal refusals, Individual #281 appeared to eat orally at the time of this review, and Individual #165 used the tube only for medication administration. Thirty-seven were identified as NPO, four received pleasure feedings, and nine individuals were listed with oral intake for full or partial meals. A sample of 10 APENs was requested, as completed since the previous review. Ten were submitted as completed for Individual #317, Individual #167, Individual #306, Individual #176, Individual #149, Individual #302, Individual #325, Individual #32, Individual #116, and Individual #301. • At least 10 of 10 individuals (100%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 4 of 10 individuals with APENs (40%) had an appropriate evaluation to	Noncompliance

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		determine the medical necessity of the tube since the previous review. Most did not appear to present a determination if the feeding schedule was the least restrictive or if there were potential modifications needed in preparation of transition to oral intake. There was insufficient assessment by the dietitian and, in most cases, the diet order and rate were not reported. The oral motor assessments were significantly improved. • For --% of individuals (NA), for whom the IRRF were submitted, there was evidence of adequate discussion by the team related to the medical necessity of the team. IRRFs were not available for review. • --% of individuals who received enteral nourishment and were admitted since the last review (NA) had a review of the medical necessity of the feeding tube within 30 days. No one who received enteral nutrition had been admitted to SASSLC since the previous review. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • Four of the individuals who received enteral nutrition (Sample O.3) were adequately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. • None of the individuals who were identified as potentially benefitting from oral motor treatment and/or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process • None of the individuals' plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP and the ISP or ISPA. • None of the individuals' plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. • --% of 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. This could not be determined. • The IDT met and interventions in the return to oral intake plans were reviewed and changed, as appropriate, in a timely manner. This could not be determined. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be: • Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan.	

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		PNMPs All individuals who received enteral nutrition in the selected sample had been provided a PNMP and positioning plan that addressed positioning during enteral intake only, rather than a Dining Plan. The monitoring team concurred with SASSLC's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish protocol related to the completion of assessments, especially related to nutrition evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 2. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP, IRRF, and IHCP, as appropriate. 3. Establish clear support plans with clinical indicators for individuals with potential to return to oral intake and/or who would benefit from therapeutic intervention to address issues that may be barriers to return to oral intake.	

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:** <u>Documents Reviewed</u>: o SASSLC client list o Admissions list o Staff list o Section P Presentation Book and Self-Assessment o Section P QA Reports o OT/PT Procedures o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates o Completed Effectiveness Monitoring sheets submitted o Completed Compliance Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists of Individual Risk Levels o List of Individuals with Poor Oral Hygiene o Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Documentation of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Documentation of competency-based staff training submitted o PNM/Assistive Equipment Maintenance Log o List of Individuals Who Received Direct OT and/or PT Services

	○ OT/PT Assessment template and instructions ○ OT/PT Assessment Tracking Log ○ Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to SASSLC: Individual #305, Individual #290, and Individual #338. ○ OT/PT Assessments, ISPs, and ISPAs, and other documentation related to OT/PT supports and intervention for the following individuals: Individual #215 and Individual #37. ○ OT/PT Assessments, ISPs, ISPs, SAPs, and other documentation related to indirect OT/PT supports for the following individuals: Individual #41, Individual #273, Individual #106, Individual #81, Individual #55, and Individual #105. ○ Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. ○ PNMP section in Individual Notebooks for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. ○ Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. <u>Interviews and Meetings Held</u>: ○ Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director ○ Allison Block-Trammel, MA, CCC-SLP ○ Edward Harris, DPT ○ JoAnna VanHoove, OTR ○ Jose Gallana, PT ○ Retha Morgan-Skinner, OTR ○ Wilfredo Diaz, DPT ○ Various supervisors and direct support staff

	Observations Conducted: o Living areas o Dining rooms o Day program areas o ISP for Individual #90
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado Gaitan, MS, CCC-SLP, Habilitation Therapies Director, was the best to date. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. The current leadership and the other therapy staff were on track to ensure that progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself in continued substantial compliance with P.1 and the monitoring team concurred. The monitoring team also rated P.3 in substantial compliance. While the actions taken continue to demonstrate consistent progress, the monitoring team determined that P.2 and P.4 were not yet in substantial compliance. A focus on ISP representation consistent with the pre-ISP and inclusion of all OT/PT supports and services must be integrated into the ISP action plan, IHCP, and/or IRRF. Additionally, implementation of compliance and effectiveness monitoring should be carefully reviewed to ensure it is conducted at the recommended frequency and across all aspects of the PNMP. Effectiveness monitoring of indirect SAPs should also be consistent. Overall, progress had continued and the plan outlined was a sound one and, combined with the findings of this report, should guide them to make greater strides over the next six months.
	Summary of Monitor's Assessment: OT/PT assessments continued to improve and substantial compliance with P.1 was maintained. The essential element section should be carefully reviewed so that content of some elements can be further refined. Further integration of OT/PT-related supports and services must be better integrated into the ISP. Supports introduced in the interim must be reflected via assessment and also be reflected in an ISPA. The clinicians should continue to be challenged to examine the existing plans to determine if supports are effective, but also least restrictive. A very clear and sound rationale must be delineated, rather than continue the same supports merely because they have been in place for some time.

	The therapists spent a considerable amount of time looking at individuals in an "out of the box" manner and were proud to show off what they had accomplished over the last six months. They were clearly working collaboratively with other team members to arrive at effective solutions. They must now take the next step to build on the foundation laid by increasing the functional and meaningful aspect of active treatment. This will be accomplished only by continuing to work shoulder to shoulder with staff in the homes and day programs to model interaction for implementation of group activities and SAPs. These should be important to the individual, a priority in their life to add quality, capitalize on interests, and promote independence in a meaningful way. The therapy clinicians are excellent and truly dedicated to the individuals living at SASSLC. They all appeared to work well as a team and as members of the IDT. The ongoing consistency of the OT/PT staff bodes well for the department. <u>Samples for Section P:</u> • Sample P.1: 17 individuals for whom an individual record and the most current OT/PT/SLP assessment were submitted. • Sample P.2: 4 individuals newly admitted in the last six months for whom a current assessment was submitted. • Sample P.3: 3 individuals who were provided direct OT and/or PT services per the list submitted. • Sample P.4: 6 individuals who were provided indirect OT/PT recommended SAPs.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified	<u>Assessments</u> Assessments were appropriately completed per the ISP schedule, change in status, or IDT request. There was a tracking log of assessments completed for ISPs from 9/3/13 through 3/26/14, but it was not possible to track when the most current comprehensive assessment had been completed and whether the assessments documented were Comprehensive or Assessments of Current Status/Updates. By report, however, all individuals had received a Comprehensive Assessment. The OTs and PTs completed a Comprehensive Assessment and/or an Assessment of Current Status/Update with the SLPs adding content related to dysphagia and a very limited overview of communication. The SLPs also completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status/Update. At the time of this review, some changes had been made to the standard format for these reports (per the state office) and were in use as of 10/1/13. All individuals newly admitted to SASSLC were to be provided a comprehensive assessment of communication completed within 30 days of admission. All individuals were to be provided a Comprehensive Assessment every three to five years, unless related	Substantial Compliance

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	manner.	to a significant change in status or special IDT request. An Assessment of Current Status was to be provided annually in the interim for individuals who received direct and/or indirect services in years that a Comprehensive Evaluation was not required. Based on this log, timeliness since 8/16/14 was 94%. The following individuals in Samples P.1 had Comprehensive Evaluations current within the last 12 months (dates listed are the signature dates): 1. Individual #188 (7/16/13) 2. Individual #154 (6/20/13) 3. Individual #277 (1/15/14) 4. Individual #230 (9/5/13) 5. Individual #313 (9/24/13) 6. Individual #142 (1/21/14) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation submitted and/or contained in his or her individual record: 1. Individual #199 (3/4/14) 2. Individual #25 (1/15/14) 3. Individual #124 (3/19/14) 4. Individual #259 (3/25/14) 5. Individual #226 (2/11/14) 6. Individual #254 (11/26/13) 7. Individual #233 (6/3/13) There were no associated comprehensive assessments for the Assessment of Current Status for Individual #349, Individual #38, or Individual #56. Four individuals had comprehensive assessments completed in 2012, with no evidence of a subsequent Assessment of Current Status or update in 2013 as required, because each was provided OT/PT supports and services (Individual #226, Individual #124, Individual #25, and Individual #199). Individual #149 had a Comprehensive Assessment dated 2/14/13, with no more current assessment within the last 12 months, though it had been recommended that she be evaluated annually. The tracking log listed that one had been completed on 2/27/14, but it was not included in her individual record. <u>Timeliness of Assessments</u> Four individuals were admitted to SASSLC since the last review. A Comprehensive Evaluation was submitted for three of these (Individual #305, Individual #290, and	

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		Individual #338). The tracking log listed that an assessment for Individual #148 was completed on 2/27/14, but likely after the document submission. • 4 of 4 individuals in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the signature dates of the assessments submitted for review (and the tracking log). The following metric was not applied because SASSLC did not use an OT/PT screening for individuals newly admitted to the facility, so no screenings were submitted for review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening, received a comprehensive OT/PT assessment within 30 days of identification. There were 16 of 17 current OT/PT evaluations and ISPs submitted for Sample R.1. Again the exception was Individual #149. Timeliness of the current OT/PT assessments was as follows: • 12 of 17 individuals' OT/PT assessments or updates (71%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 60% in the previous review. Based on signature dates, and actual working days, the following assessments did not appear to have been completed 10 working days <u>prior</u> to the ISP: Individual #124, Individual #56, Individual #154, and Individual #188. Each of these had been completed prior to the ISP, however. Further, these assessments had been completed prior to 9/1/13 and were not included in the tracking log. As stated above the percentage for the most current assessments since that time was 94%, representing a substantial improvement since the previous review. • 16 of 17 assessments (94%) were current within 12 months for individuals in Sample P.1 who were provided PNM supports and services. This was a decrease from 100% in the previous review. Though the tracking log indicated that a current assessment for Individual #149 had been completed, it was not present in her individual record. <u>OT/PT Assessment</u> Only current Comprehensive Evaluations included in Sample P.1 were included in the following analysis (7). The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. The analysis for comprehensiveness of the OT/PT/SLP assessments was as follows: • 6 of 6 assessments (100%) were signed and dated by both OT and PT clinicians upon completion of the written report. This was consistent with the previous review.	

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		• 6 of 6 assessments (100%) included medical diagnoses. This was consistent with the previous review. • 6 of 6 assessments (100%) included medical history. This was consistent with the previous review. • 6 of 6 assessments (100%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was an improvement from 90% in the previous review. This was more specifically related to current health status and risk, but less so related to previous history and diagnoses. • 6 of 6 assessments (100%) addressed health status over the last year. This was consistent with the previous review. • 5 of 6 assessments (83%) included comparative analysis that clearly analyzed health status compared with previous years or assessments (all but Individual #154). This was a decrease from 90% in the previous review. • 5 of 6 assessments (83%) included a section that reported health risk levels that were associated with PNM supports (all but Individual #154). This was a decrease from 100% in the previous review. • 6 of 6 assessments (100%) listed medications and potential side effects relevant to functional status. This was an improvement from 90% in the previous review. • 6 of 6 assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 6 of 6 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was consistent with the previous review. • 6 of 6 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This was consistent with the previous review. • Four individuals required a wheelchair for some level of mobility, though only Individual #230 used a wheelchair for her primary means of mobility. The others used a wheelchair for long distances as needed. 4 of 4 assessments (100%) included a description of the current seating system with a rationale for each component and need for changes to the system were outlined as indicated, also with sufficient rationale. This was an improvement from 78% in the previous review. • 6 of 6 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. Two individuals had not received all of the monitoring as required (Individual #154 and Individual #313). The frequency of monitoring was not reported in all cases, though this would be a good practice to ensure that it occurred as recommended by the clinicians in the assessment reports. This was consistent with the previous review.	

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		• 6 of 6 assessments (100%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. This was consistent with the previous review. Though generally present, this was often implied rather than clearly stated. For example in the case of Individual #142, it was reported that he had 28 falls in the last 12 months, one resulting in a hairline fracture to his left ankle. This resulted in the use of four-wheeled walker and soft shell helmet for safety, but he was otherwise independent. This should instead compare the last 12 months to functional status in the previous year, in this case 1/21/13 to 1/21/14 compared to 1/21/12 to 1/21/13. For example, it would be an important to report the number of falls he had in that previous year compared to the 28 falls in the last 12 months. It should be noted that this was addressed more appropriately in a number of the Assessments of Current Status as addendums to the Comprehensive Assessment. • 6 of 6 assessments (100%) included documentation of the efficacy and/or introduction of new supports in the PNMP that address the individual's PNM risk levels. This was an improvement from 90% in the previous review. • 6 of 6 assessments (100%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 90% in the previous review. • 6 of 6 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was consistent with the previous review. • 6 of 6 assessments (100%) included a monitoring schedule. This was consistent with the previous review. Though the frequency of compliance monitoring was clearly stated, it was not clear in each case as to the frequency of effectiveness monitoring. • 6 of 6 assessments (100%) included a re-assessment schedule. This was consistent with the previous review. • 6 of 6 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 6 of 6 assessments (100%) detailed the supports and services needed for successful community living, though these descriptions generally only listed the equipment needed, or in one case, indicated that the individual needed all of the supports she currently was provided. There was no discussion of environmental adaptations needed for home or work, level of supervision, or needs for OT and/or PT services. This section should provide an overview of special indications that should be considered if the individual was going to transition to the community from the perspective of the OT and PT. It should be noted that	

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		this was addressed more appropriately in a number of the Assessments of Current Status as an addendum to the Comprehensive Assessment. The approach used in those assessments should also be applied to the Comprehensive Assessments. • 6 of 6 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. The Assessment of Current Status was considered an update to the previous Comprehensive Assessment. In that case, the existing Comprehensive Assessment should be available in the active record along with each subsequent Assessment of Current Status, until such time that the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There was a new assessment format recently developed by the state and distributed. These contained standardized main headings were to be used by all disciplines. The facility had implemented these changes. Further findings revealed continued improvements related to OT/PT assessments as follows: • 5 of 6 assessments (83%) contained 100% of the 22 elements listed above. There were improvements in seven of the elements. • There was a decrease for two elements. • 13 elements were consistent with the previous review at 100%. There were 10 individuals in Sample P.1 for whom records were submitted with current Updates/Assessments of Current Status, and seven had associated Comprehensive Assessments submitted and/or contained in the records (the exceptions were Individual #56, Individual #349, and Individual #38). There were Comprehensive Assessments and a current Assessment of Current Status completed in the last 12 months, but no evidence of an interim update for the following: Individual #124 Individual #25, Individual #226, and Individual #199. For example, in the case of Individual #226, her Comprehensive Assessment was completed on 3/6/12 and her Assessment of Current Status was completed on 2/11/14, with no evidence of an update in 2013. • For 9 of 10 individuals for whom Updates/Assessments of Current Status were completed (90%), the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. There was no monitoring schedule identified for Individual #56 (5/23/13)	

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		There was continued overall improvement in the quality of OT/PT assessments for this review period, including an improvement of on-time assessments submitted 10 working days prior to the ISP. There was an audit system in place involving review for a sample of assessments. This continued to be an appropriate approach as all clinicians were reported to have demonstrated competency with the elements identified above. SASSLC maintained substantial compliance with provision P.1. The facility continued to demonstrate improved compliance with the quality of OT/PT assessments and employed ongoing measures to ensure that assessments were completed by the due dates (10 working days prior to the ISP). To maintain substantial compliance with this provision, consider a focus on the following: 1. Ensure that the audit system promotes improvements in the content of OT/PT assessments at or near 90% which is the standard held by the monitoring team. The two elements that fell below this were related to one assessment only. Though given credit, some of the other elements were lacking in some aspects. The points identified in the following essential elements should be addressed with the clinicians: o Comparative analysis that clearly analyzed health status compared with previous years or assessments. o Reported health risk levels that were associated with PNM supports. o Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. o A comparative analysis of current functional motor and activities of daily living skills with previous assessments. o Detail the supports and services needed for successful community living. 2. The ACS should address essential findings from the last year, but should not be equivalent to a full comprehensive assessment. This will permit these to be completed in less time and permit more opportunities for direct supports and interventions.	
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	<u>Direct OT/PT Interventions:</u> There were 3 individuals listed as participating in direct OT and/or PT and each was included for review in Sample P.3 (Individual #215, Individual #233, Individual #37). One additional individual in P.1 also previously participated in direct PT (Individual #313). • For 4 of 4 individuals (100%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. • 3 of 4 individuals had direct intervention plans (75%) implemented within 30 days of creation or sooner as indicated by the individual's health and safety. In	Noncompliance

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	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.	the case of Individual #37, the intervention was implemented on the plan initiation date, but this was over two months after the assessment identified this need and over one month after the ISP. In the case, that an individual is already participating in direct therapy, the treatment plan should be reviewed and updated as indicated at the time of the ISP with a new start date or review date within 30 days of the ISP to be considered implemented in a timely manner. This should be documented in the plan and IPNs (or other treatment documentation) in order to show continuity of service. There was no documentation to explain why there had been a significant delay in implementing this recommendation. • For 0 of 3 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. There was no mention of direct therapy for Individual #37 in her ISP dated 8/14/13. Though content from the OT/PT assessment copied into the ISP (2/12/14) included the recommendation for direct therapy for Individual #215, the stated objectives were not included in the action plan. Individual #233 fractured her pelvis in September 2013, with an ISPA related to this serious injury on 9/9/13. PT provided follow-up assessment on 9/24/13 as indicated in the ISPA on 9/12/13, but there was no ISPA to begin direct therapy. Individual #313's therapy was provided in April 2013 and the ISP/ISPAs from that time period had been appropriately purged from his individual record, so this could not be determined for him. • For 1 of 1 individual (100%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner (Individual #313). The system for documentation was consistent for each of the individuals reviewed. There was a combination of session data collection sheets, weekly progress notes, and monthly progress reports. Progress notes/IPNs: • 3 of 3 individuals receiving direct OT/PT Services (100%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: o Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	

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		Documentation was generally consistent and excellent. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. Additional SAPs were developed for implementation by DSP staff with monitoring by OT/PT. Examples of these were submitted for review. Documentation of the sequence of assessment recommendation, integration into the ISP, and the development of the SAP for implementation by DSP or day program staff was evident for 6 of 6 individuals (100%). There was no evidence submitted related to effectiveness monitoring conducted by the OT or PT, however. <u>Integration of OT/PT Interventions, Supports and Services in the ISP</u> Review of the PNMP and Dining Plans were required by the IDT at least annually during the ISP meeting. Likewise, all other supports and services provided through OT/PT should be reviewed by the IDT and well integrated into the ISP and/or ISPA. This requires that key team members be present, including the OT and/or PT clinicians. As described above, the ISPs or ISPAs for individuals in the sample who participated in direct OT or PT services did not consistently establish the need to begin or terminate therapy. The current system also required that the IDT designate which team members were required to attend the annual ISP during the pre-ISP meeting. Pre-ISP documentation and ISPs were requested for individuals included in Sample P1. Individual #233 was duplicated in Sample P.2, for a total of 19 individuals. Pre-ISP required attendance sheets were not submitted for four individuals (Individual #142, Individual #37, Individual #215, and Individual #149). Review of the ISPs submitted was as follows: • 95% (18 of 19) of the ISPs submitted were current within the last 12 months (exception was Individual #149 with ISP dated 2/26/13, though the facility reported that she had been hospitalized and the ISP had been delayed until 3/26/14. This was not available to the monitoring team.). • 95% (18 of 19) of the current ISPs had attached signature sheets. • 21% (4 of 19) of the current ISPs with signature pages submitted were attended by both the OT and PT (Individual #118). • 47% (9 of 19) were attended by PT only. • 66% (3 of 19) were attended by OT only. • 5% (1 of 19) of the current ISPs had no representation by an OT or PT (Individual #188). Per his assessment, he did not have any identified OT/PT-related needs. • In the case of Individual #56, the PNMT OT was in attendance with the SLP only.	

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		Of the 15 individuals for whom pre-ISP required attendance sheets and ISP signature sheets were submitted, 12 designated required attendance by OT and/or PT. Nine of these were attended as designated by the IDT (75%). One did not designate OT or PT to be present, but the ISP was attended by the PT. In two cases, the IDT designated a Habilitation Therapy representative and these were attended by the SLP and, in the case of Individual #56, also the PNMT OT. In the case of Individual #230, OT was the designated attendee, though PT was present. In the cases of Individual #25 and Individual #154, OT and PT were designated to attend, but only a PT representative was present. The facility needs to clearly establish a rationale for attendance by all team members and, once established, attendance should be consistent with this rationale. Clinicians may find the need to negotiate their attendance based on actual services and supports provided and/or proposed to be provided. This element was self-rated to not be in substantial compliance and the monitoring team concurred. Very few individuals received direct therapy services, though documentation related to this was generally within standard practice. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Competency-Based Training</u> Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element.	Substantial Compliance

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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.	The facility had a current OT/PT policy and very detailed procedures that addressed the following and were in practice at the time of this review: • 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. <u>Monitoring System</u> The facility implemented a system for the adequate monitoring of PNMPs conducted by the PNMPCs. This included staff compliance for implementation of PNMPs and the condition and availability of adaptive equipment. Further, PT was responsible to monitor individuals for a current PNMP and whether it was followed by staff. OT was responsible for monitoring individuals for a current Dining Plan and whether it was followed by staff. The standardized system for compliance monitoring of the PNMPs and Dining Plans consisted of a determination of frequency outlined in the OT/PT assessment based on a flow chart related to risk levels. This was generally conducted by the PNMPCs and clinicians in conjunction with effectiveness monitoring. • The tools included adequate indicators to determine whether staff demonstrated competency to safely and appropriately implement the PNMP. • There were sufficient instructional guidelines for those using the forms to monitor. • All monitors (PNMPCs) and therapy clinicians were competent to monitor the PNMP elements based on the training submitted.	Noncompliance

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		Though much work had been done to refine the existing system since the last review as outlined above and in section O.6, it did not appear that all areas of the PNMP had been consistently monitored based on the forms submitted. Per the current assessments submitted, frequency for the individuals in Sample P.1 was as follows: <u>PNMP Monitoring</u> • Three times per month: Individual #254, Individual #38, and Individual #277 • Monthly: Individual #142, Individual #259, and Individual #226 • Eight times per year: Individual #233, Individual #199, Individual #124, and Individual #230 • Six times a year: Individual #25 • Quarterly: Individual #313 and Individual #154 • Bi-annually: Individual #349 (This frequency was of concern to the monitoring team because he was identified at high risk for aspiration, was enterally nourished and was not recommended for mealtime monitoring). • There was no recommendation for PNMP monitoring for Individual #56, though he was identified with a PNMP related to enteral nutrition and this would be expected. • There was no recommendation for PNMP monitoring for Individual #188. His PNMP was related to dining only as he was independent in other areas and had no special need for physical management supports. • There was no current assessment for Individual #149 as described above in P.1. <u>Mealtime Monitoring</u> • Three times per month: Individual #277 • Six times per year: Individual #25, Individual #254, Individual #38```, and Individual #230 • Eight times per year: Individual #124 • Ten times a year: Individual #313 • Quarterly: Individual #233, Individual #154, and Individual #142 • Biannually: Individual #188 • There was no recommendation for mealtime monitoring for Individual #56, Individual #199, Individual #226, Individual #349, and Individual #259 though they were identified with Dining Plans/PNMPs related to enteral nutrition and this would be expected. • There was no current assessment for Individual #149 as described above in P.1. The forms submitted were reviewed to determine if monitoring was completed as per the established schedule and if all areas of the PNMP had been reviewed, across all shifts within that time frame.	

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		Findings were as follows: • PNMP Monitoring was not conducted at the established frequency described in the assessments for 7 of 17 individuals. As stated above, there was no current assessment for Individual #149, though she was monitored in January 2014 and in March 2014. The other six individuals were Individual #124, Individual #254, Individual #38, Individual #154, Individual #142, and Individual #277. • This could not be determined for Individual #56 because there was no recommendation for monitoring, though this was indicated. PNMP monitoring was conducted over the previous quarter. • While collectively, monitoring occurred across all three shifts, this was not the case for each individual. Overall, approximately 60% of the PNMP monitoring occurred on first shift, 27% on second shift, and 9% on third shift. • Across 44 monitoring forms completed for 17 individuals, only two involved bathing, one related to oral hygiene, one related to medication administration, and two related to mealtime. • It was noted, however, that the PNM monitoring process did not adequately balance all areas that were likely to provoke swallowing difficulties, or increase other PNM risk, including: o Meals o Bed positioning o Wheelchair positioning o Medication administration o Oral care o Bathing o Transfers • Mealtime Monitoring was not conducted at the established frequency described in the assessments, for 8 of 17 individuals. As stated above there was no current assessment for Individual #149, though she was monitored twice in January and twice times in February 2014. The other seven individuals were Individual #124, Individual #254, Individual #38, Individual #154, Individual #233, Individual #25, and Individual #277. • This could not be determined for Individual #56 because there was no recommendation for monitoring, though this was indicated. Mealtime monitoring was not conducted over the previous quarter, though he was enterally nourished. PNMP monitoring was conducted, but none during a tube feeding. • While collectively, monitoring occurred across all meals, this was not the case for each individual. Overall, approximately 27% of the mealtime monitoring occurred at breakfast, 55% at lunch, 14% at dinner, and 5% during a snack (10:05 pm for Individual #38).	

#	Provision	Assessment of Status	Compliance
		• Five individuals were not recommended for mealtime monitoring because they were enterally nourished (Individual #199, Individual #226, Individual #349, Individual #56, and Individual #259). No mealtime monitoring was conducted for any of these individuals. This was of significant concern to the monitoring team as each had been identified as high risk for aspiration. Only in the case of Individual #199 did any PNMP monitoring occur during a meal (1/23/14), assumed to be enteral nutrition as he was NPO. PNMP monitoring for positioning was reported to be conducted during tube feeding for Individual #349 and Individual #56 using the Physical Management Monitoring Tool. • Individual #277 was recommended for mealtime monitoring three times per month, yet there was no evidence that this had been conducted even once over a three month period. He also had only been monitored related to his PNMP on one occasion (1/7/14), though this had also been recommended three times per month. On that date it was documented that monitoring had occurred during a tube feeding. This was of significant concern to the monitoring team because he was identified at high risk for aspiration. There was also a system established for effectiveness monitoring by the therapists, though this was not clear based on the documentation submitted. The frequency of this was not reported in the annual assessments. Effectiveness monitoring guidelines should indicate that this should occur as follows: • Monitor upon initiating a new plan • Monitor upon modifying a plan • Monitor following identified issues or concerns • Monitor no less than quarterly, unless there was a clear rationale Based on the sample of individuals selected for P.1, evidence of effectiveness monitoring for each was requested for the last six months. This was provided for January 2014 to March 2014 only, for 13 of 17 individuals included in Sample P.1. The compliance monitoring form included a section that addressed effectiveness monitoring and both were conducted in conjunction by the OT and/or PT. Only six forms addressed the effectiveness of the Dining Plan for three individuals: Individual #230 (2), Individual #313 (3), and Individual #142 (1). All others were related to the PNMP, though two of these occurred during a tube feeding (Individual #199 and Individual #226) and another during a meal (Individual #313). • Based on the monitoring team's direct observation of over 50 individuals, over 90% of positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Based on review of the maintenance log, individuals for whom adaptive	

#	Provision	Assessment of Status	Compliance
		equipment was noted to be in disrepair or needing replacement, equipment was repaired or replaced within 30 days, or unless the issue impacted the individual's health or safety, then action was taken within 48 hours. All equipment was checked at least quarterly for presence and condition related to the compliance and effectiveness monitoring systems. This element was self-rated to be in noncompliance. While there was an established system of compliance and effectiveness monitoring, compliance with the recommended frequency appeared inconsistent based on the sample reviewed. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish benchmarks, a tracking system and schedule for effectiveness monitoring by OTs and PTs. It appeared that monitoring was done, but there was no clear method to determine if all areas of the PNMP were addressed at an established frequency. Effectiveness monitoring of the Dining Plan appeared to occur infrequently. 2. Ensure that compliance monitoring was consistently conducted related to all aspects of the PNMP at the recommended frequency.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/15/13 o SASSLC Organizational Charts o SASSLC Self-Assessment Section Q o SASSLC Action Plan Section Q o SASSLC Provision Action Plan o SASSLC Dental Operating and Procedure Manual, 7/10/10 o SASSLC Policy Q.3, Suction Toothbrushing, 8/12/13 o SASSLC Policy Q.4, Chlorhexidine Protocol 8/12/13 o SASSLC Policy Q.5, Dental Emergency, 2/23/14 o SASSLC Policy Q.6, Dental Radiographs, 2/23/14 o SASSLC Policy Q.7, General Anesthesia Medical Clearance 1/23/14 o SASSLC Policy Q.8, Dental Anesthesiologist, 1/23/14 o SASSLC Policy Q.9, General Anesthesia Recovery, 1/23/14 o SASSLC Medical/Dental Restraints 1/24/12 o SASSLC Consent and Authorization for Treatment and Services, 10/11/12 o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o SSLC Dental Conference Call Notes o SSLC State Dental Conference Notes o Dental Records for the Individuals listed in Section L o Listing, Individuals Receiving Pretreatment Sedation o Listing, Individuals Receiving Treatment with TIVA o Complete Dental Records for the following individuals: • Individual #4, Individual #342, Individual #339, Individual #206, Individual #92, Individual #252, Individual #154, Individual #169, Individual #340, Individual #50 o Annual Dental Summaries for the following individuals: • Individual #30, Individual #36, Individual #294, Individual #217, Individual #136, Individual #177, Individual #220, Individual #226, Individual #9, Individual #141, Individual #129, Individual #45 o Anesthesia Records for the following individuals: • Individual #287, Individual #244, Individual #32, Individual #88, Individual #94, Individual #309

	Interviews and Meetings Held: o Alvydas Kukleris, DDS, Dental Director o Amy Jo Hush, RDH, Dental Hygienist Observations Conducted: o Dental Clinic
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted two documents: the self-assessment and the action plan. The dental director described, for both provision items, a series of activities engaged in to conduct the self-assessment. As noted during the October 2013 review, SASSLC did not appear to use the standardized self-assessment utilized by the other SSLCs. This self-assessment included approximately 36 assessment items that covered many of the areas reviewed by the monitoring team, such as radiographic compliance, provision of oral hygiene instructions, review of checklist for vital signs associated with anesthesia, and many others. SASLC continued to complete the original 13-point self-assessment, which did not adequately assess the provision of services at the facility. This was noted in the last compliance review, but unfortunately did not change. Generally, the self-assessment should look at the same types of items that are reviewed by the monitoring team. Use of the state template will aide tremendously in achieving that goal. The facility rated itself in noncompliance for both provisions. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: There were a number of positive findings during this review. Individuals received timely annual assessments and were scheduled for necessary treatments. Treatment required consent and the extended delays related to the consent process and HRC approval continued to decrease. Although the clinic did not actively track compliance with obtaining radiographs, data indicated that approximately 83% of individuals had current x-rays. A policy detailing the facility's guidelines for obtaining radiographs was developed and approved. Oral hygiene continued to be a significant problem for the facility. More than 30 percent of individuals maintained poor hygiene status. It did not appear that current efforts were making any substantial impact in this area. TIVA was another major concern. The use of intravenous anesthesia requires careful selection and monitoring of individuals. The facility developed procedures related to TIVA and this was good to see.

	However, those procedures did not adequately address perioperative evaluation. Moreover, the documents reviewed by the monitoring team provided no evidence of the appropriate post-anesthesia monitoring. The facility also had data reporting issues that translated into larger concerns. Refusals were incorrectly recorded. Only those individuals who refused to go to clinic were documented as refusals. Individuals who presented to clinic, but refused treatment, were deemed uncooperative. They were not included on the list of refusals for evaluation by behavioral health services. They were rescheduled for clinic with the use of oral sedation or TIVA. It appeared that the dental clinic was capable of providing the necessary care, but needed additional supports in order to move towards substantial compliance. Three major areas that require attention are (1) oral care in the homes, (2) identification of individuals who refuse treatment coupled with an evaluation by behavioral health services, and (3) assessment and correction of issues related to the use of TIVA.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff and dental director. <u>Staffing</u> The dental department was fully staffed with a dental director, dental hygienist, and dental assistant. The dental director reported to the medical director. The hygienist and dental assistant were supervised by the dental director. All were full time employees. There were no staffing changes since the last compliance review. <u>Annual Assessments</u> The monitoring team requested a list of annual assessments completed in the last six months, listed by month. The facility submitted a list of assessments completed each month. Assessments were completed within 365 days of the previous assessment. The data from the documents submitted are presented in the table below. Annual Assessment Compliance 2013 - 2014 | | Sep | Oct | Nov | Dec | Jan | Feb | | No. of Exams Completed | 21 | 45 | 21 | 1 | 20 | 19 | | % Timely Completion | 70 | 88 | 91 | 100 | 100 | 100 | The average compliance for the six-month reporting period was 91%. This was a slight decrease from the compliance rate of 94.5% noted during the October 2013 review.	Noncompliance

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		Ten Annual Dental Examinations were submitted as part of the complete records. The Dental Record Annual Examination included information on behavior classification, oral hygiene, tissues, management needs, medical/physical limitations, medical history, intra-extra oral exam, periodontal disease, caries, and radiographs. The state dental coordinator explained during previous reviews that item number 10 addressed periodontal disease and item number 11 addressed dental caries risk. Both items were rated mild, moderate, and severe. Risk is usually assessed as high, medium, and low and most SSLCs typically use that nomenclature when describing dental risk. It appeared that item number 11 continued to address actual dental caries and this form, which had not been updated since 2005, did not have a specific item to address periodontal or dental caries risk. However, risk ratings were documented in the Annual Dental Summaries. The assessment form did not include information on positioning or provision of oral hygiene instructions. The dentist did, however, comment on positioning in the SOAP DPN entries. There was infrequent documentation regarding the provision of oral hygiene instructions. In addition to the completion of the evaluation form, the dentist also documented in the Dental Progress Notes. The DPN entries were dated, timed, and signed. All of the notes reviewed were completed in SOAP format. Each assessment summarized the services provided, the exam findings, types of x-rays completed, and any abnormal x-ray results. The plan of care was documented. A pointer note was made in the IPN indicating that the examination was completed. State office issued a new annual exam template in February 2014. SASSLC did not implement this template. The dental director reported that the annual examination template was linked to state dental policy and the unified records department would not allow the new template to be implemented until the state policy was updated to include the new template. This is also the reason that the facility had not made any changes to the annual assessment form. The dental director reported that no changes were allowed. This appeared to be a facility level issue, which was no longer relevant for the annual assessment with the issuance of the state template, but needs to be addressed because it may impact the ability to change other documents. The Annual Dental Summary was a chart review completed in preparation for the ISP. A state-issued template was implemented in December 2013. This summary included information on current oral hygiene, tissue status, and use of sedation. It also documented periodontal condition and each assessment included an odontogram. The use of the odontogram key required a color copy for interpretation. It was not helpful in black and white copies. Comments related to preferences, strengths, goals, and community living and services were included.	

#	Provision	Assessment of Status	Compliance

		Copies of 12 Annual Dental Summaries were submitted for review. The following summarizes the data included in those documents:
		• 12 of 12 (100%) had an entry concerning behavioral issues, and the need for sedation/restraint use
		  o 10 of 12 (83%) documented that TIVA was required for evaluation and treatment
		• 12 of 12 (100%) documented oral hygiene status
		• 12 of 12 (100%) documented oral cavity tissues
		• 12 of 12 (100%) included a completed odontogram
		• 12 of 12 (100%) documented treatment recommendations
		• 12 of 12 (100%) documented risk ratings specific to periodontal disease and caries
		• 7 of 12 (58%) documented the dates of the last radiographs
		  o 1 of 12 (8%) individuals was edentulous
		• 10 of 12 (83%) included comment on community and living services
		• 10 of 12 (83%) included comments on preferences, strengths, and goals.
		• 1 of 12 (8%) assessments was not completed
		
		<u>Initial Exams</u>
		Two individuals were admitted during the reporting period. The assessments for both individuals were completed within 30 days of admission.
		
		<u>Oral Hygiene</u>
		The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported:
		
		Oral Hygiene Ratings 2013 -2014 (%)
		| | Good | Fair | Poor |
		| Apr- June | 22 | 43 | 35 |
		| Jul-Aug | 21 | 44 | 35 |
		| Sep - Nov | 23 | 43 | 34 |
		| Dec -Feb | 18 | 44 | 38 |
		
		The dental director reported that the clinic continued to train staff and work more closely with unit directors in order to improve the hygiene status of the individuals. Facility data indicated that oral hygiene remained problematic. More than 30% of individuals consistently had poor oral hygiene. Previous attempts to conduct toothbrushing clinics and to provide toothbrushing instructions in the homes were not successful. Clinic notes frequently documented that home care was poor. Clinic notes also failed to document that oral hygiene instructions were provided to the staff and	

#	Provision	Assessment of Status	Compliance
		individuals. It appeared that oral hygiene rating varied by homes. The dental director explained that the clinic staff was beginning to work more directly with the unit directors in an effort to improve oral hygiene. Suction Toothbrushing Thirty-five individuals received suction toothbrushing. Chlorhexidine and Biotene were alternated at 14-day cycles. Individuals were identified by the dentist who discussed the recommendation with the primary care provider. If there was agreement by the IDT, the dentist proceeded with writing orders for the treatment. According to the policy, individuals at risk for aspiration, those who received enteral nutrition, and those with a diagnosis of oral dysphagia may be prescribed a treatment that included suction toothbrushing. There were no changes in the policy, which did not describe how the individuals would be identified, which provider was responsible for writing the order, or how the facility would ensure the treatments were provided. The facility needs an operational procedure that describes every aspect of the program such that any new staff could read the procedure and have adequate knowledge of how the program operates. Preventive, Restorative, and Emergency Services The dental clinic had three operatories and provided services five days a week. Dental services included prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The total number of clinic visits and key category visits are summarized below. The total number of clinic visits and key category visits are summarized below. Clinic Appointments 2013 - 2014 | | Sep | Oct | Nov | De | Jan | Feb | | Preventive | 22 | 54 | 43 | 35 | 42 | 42 | | Emergency | 1 | 4 | 3 | 2 | 4 | 3 | | Extractions | 0 | 1 | 1 | 8 | 2 | 0 | | Restorative | 3 | 6 | 6 | 2 | 4 | 8 | | Total | 70 | 121 | 89 | 81 | 88 | 80 | The overall number of appointments did not include the appointments for individuals referred to the community dentist and oral surgeon. Eight appointments were scheduled during the reporting period. One of the eight appointments included actual treatments. The remaining seven were evaluation appointments. The total number of appointments represents the number of scheduled appointments.	

#	Provision	Assessment of Status	Compliance
		Emergency Care The clinic staff reported that emergency care was available during normal business hours. After business hours, the on-call physician was contacted and made a determination about the need for urgent dental care. The dental director was available by phone to discuss care with the primary providers. Radiographs A policy for completion of radiographs was developed. The facility's policy was based on the American Dental Association's recommendations for patient selection and limiting radiation exposure. Based on these guidelines, the dentist completed a full mouth series the first time the individual had TIVA. Select radiographs were done with subsequent treatment done with TIVA. Attempts were made to obtain bitewing examinations during annual evaluations. The facility submitted a list of 239 individuals: • 13 of 239 (5%) individuals were edentulous • 6 of 239 (2.5%) individuals were followed off campus • 32 of 220 (15%) did not have current radiographs o 24 of 220 (11%) individuals did not have documentation of any radiographs The dental clinic was not tracking compliance with the requirement to obtain radiographs even though the state issued template for the self-assessment listed radiograph compliance as one assessment item. The data reported above was based on a list constructed by the dental director during the week of the compliance review. Some data elements, such as the number of edentulous individuals, differed from that reported in other documents. Overall, for the 226 individuals with teeth, 83% had current radiographs based on the data provided. Oral Surgery A new contract had been recently finalized with a local oral surgeon and one referral was made. The facility continued to utilize the services of the community dentist who provided care under general anesthesia in a hospital setting. The individuals referred were generally those who were older or who had complex medical problems. Sedation/General Anesthesia/TIVA The facility utilized the services of a contract anesthesiologist who provided services two days each month. The following data were submitted for the use of pretreatment sedation and TIVA.	

#	Provision	Assessment of Status	Compliance

General Anesthesia/Minimal Sedation 2013 -2014						
	Sep	Oct	Nov	Dec	Jan	Feb
TIVA	3	9	9	8	7	8
Oral Sedation	3	3	4	3	6	4
Total	6	12	13	11	13	12

During the October 2013 review, the monitoring team recommended that the dental department develop policies and procedures related to the use of TIVA. The guidelines for post anesthesia care were nursing policies and there was a clear need for the dental and medical departments to outline how individuals were selected for TIVA and monitored. Policies for medical clearance and anesthesia recovery were developed. The General Anesthesia Medical Clearance policy required that each "patient must have medical, psychiatric and pharmacological clearance prior to scheduling for general anesthesia appointment." The policy did not provide guidance on how to achieve medical clearance.

The use of the term clearance incorrectly implies that the procedure carries no risk and, therefore, this term should be avoided. The PCP should identify medical problems, integrate this information with the physiologic risk of anesthesia and the procedure, anticipate perioperative problems, assess the individual's risk and need for further intervention, and communicate effectively with the anesthesiologist and dentist. It may be possible that the individual is not suitable for the proposed procedure. There are many tools and guidelines for conducting perioperative assessments and the monitoring team recommends that guidelines for conducting assessment be implemented.

The dental consultation consensus usually stated "medically clear," "no medical issues," or "no contraindications." These evaluations should provide an assessment of the individuals including the pertinent lab data that serves as the basis for those statements.

As part of the document request, the facility was required to submit the records of individuals who had TIVA, including all monitoring tapes, operative reports, perioperative checklists, post-operative checklists or monitoring forms, etc. (document XIV.19). The records of six individuals were reviewed. In each case, there was no documentation of monitoring occurring during the period of time that the individual was monitored in the dental clinic after anesthesia ended. There were sometimes one to two hour periods that lacked documentation of vital signs. Vital signs were noted by the anesthesiologist and the next set were noted upon arrival to the home. The dental director indicated during the October 2013 review that, at times, there were problems and disagreements about who would conduct monitoring in the clinic following anesthesia. He reported that issue arose once again in recent months, but was resolved.

#	Provision	Assessment of Status	Compliance
		Individual #43 had dental work completed on 3/17/14. The last EKG was done in 2012 and labs were completed on 3/10/14. This individual was reported to experience bradycardia with a heart rate of 30 – 40 following TIVA. There was no documentation of a medical assessment prior to TIVA and the vital signs following TIVA were reported as "nowhere to be found." The individual received enhanced monitoring for 24 hours prior to returning home and appeared to fully recover. The medical issues of this case are discussed in section L1. There was overwhelming evidence that there were problems related to the use of TIVA at the facility. The monitoring team could not locate documentation of appropriate monitoring as written in policy. The use of intravenous anesthesia is a very serious procedure with clear risks as illustrated by the case above. The facility must approach the use of this adjunct for dental treatment with greater caution. Staff Training All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn. Compliance Rating and Recommendations This provision remains in noncompliance. To move in the direction of substantial compliance, the monitoring team, makes the following recommendations: 1. The facility needs to proceed with implementing the recently issued state annual assessment template. 2. The facility must aggressively address the problem of oral hygiene. Facility management should become involved in this continued problem, as the percentage of individuals with poor oral hygiene is indicative of serious care issues within the facility. 3. The suction toothbrushing program must have grater oversight. 4. The facility must address the TIVA relate issues highlighted in the report.	
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;	Policies and Procedures The monitoring team requested all facility (local) policies related to the provision of dental care. SASSLC submitted new policies for dental radiographs and anesthesia. The dental department needs to have a dental department manual that includes all policies, procedures, and guidelines involving the provision of dental services to ensure that all aspects of dental services are covered. That manual should be readily retrievable and available for review by staff. Current policies did not address issues related to general operations and staffing, consent, oral hygiene tracking, dental recall, infection	Noncompliance

#	Provision	Assessment of Status	Compliance
	provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	control, and training. Additionally, local policies should be updated to reflect changes in state dental policies. The department should also ensure that policies are reviewed on an annual basis and updated as required. <u>Dental Records</u> Dental records consisted of IPN entries, exam reports (annual exams), and dental progress/treatment records and oral sedation progress notes. The entries made in the dental progress treatment record were done in SOAP format and were typed. When individuals were seen in dental clinic, an entry or pointer note was made in the IPN that indicated that the individual was evaluated. <u>Failed Appointments</u> The guidelines issued by state office required reporting of <u>missed/no show</u> appointments and <u>refusals</u>. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals. The numbers as identified and reported by SASSLC are summarized in the table below: Failed Clinic Appointments 2013 -2014 | | Sep | Oct | Nov | Dec | Jan | Feb | | Missed/No show | 3 | 3 | 2 | 1 | 0 | 0 | | Refused | 4 | 3 | 5 | 1 | 3 | 4 | | Failed | 7 | 6 | 7 | 2 | 3 | 4 | | % Failed | 10 | 5 | 8 | 2 | 3 | 5 | | Total Appointments | 70 | 121 | 89 | 81 | 88 | 80 | Each home was notified of appointments every morning between 6:30 am and 6:45 am. This was in addition to notifications that were previously sent. For the nine missed appointments reported from September 2013 through February 2014: • 1 of 9 (11%) had no reason • 6 of 9 (66%) were due to staffing • 2 of 9 (22%) were due to outings/passes When appointments were missed, they were re-scheduled. SASSLC continued to report a relatively small number of refused appointments. The monitoring team questioned the dental clinic staff about the accuracy of the data and was	

#	Provision	Assessment of Status	Compliance
		assured that it was correct. Record reviews, however, indicated that some individuals refused treatment upon arrival to clinic. The clinic staff was asked why these individuals were not listed on the refusal list. The monitoring team was informed that the refusal list included only the individuals who refused to leave their homes and go to dental clinic. If and individual arrived to the clinic and refused treatment, that individual was then rescheduled for clinic with the use of oral sedation or TIVA. This definition of a refusal resulted in under-reporting of treatment refusals and failed clinic appointments. For example, seven appointments were reported as failed in September 2013, but the clinic tracking log indicated that 12 appointments were not completed. The reason the appointments were not completed was not stated. It is possible that the failure rate was 17% rather than 10%. This would be a significant difference. It is important for the facility to address the issue of accurately reporting the data. The problem of refusals and the impact of the refusals on oral health may be significantly greater than indicated by the data reported. <u>Sedation and Dental Restraints</u> The facility documented that, for the reporting period, 8% of individuals receiving treatment used general anesthesia and 4.4% required sedation. The use of both modalities required the approval of the Human Rights Committee. The approval was obtained for all individuals. The dental department did not utilize mechanical restraints <u>Strategies to Overcome Barriers to Dental Treatment</u> As previously discussed, the actual refusal rate for the facility was unknown, but was obviously greater than reported. Developing systems to address barriers to dental treatment and refusals has proven challenging for the staff of SASSLC. Over the past few years, a number of attempts to establish workgroups and performance improvement teams were made, but to no avail. The monitoring team met with facility staff during this compliance review to discuss desensitization and strategies for overcoming barriers to dental treatment. A new process for dental desensitization was developed. The process required collaboration between behavioral health services, the dental clinic, and the IDT. Plans were written for two individuals shortly before the compliance review. There were several other individuals who were documented to have a history of refusals who were in need of assessment. While it was encouraging to see plans written for two individuals, the monitoring team has observed a pattern at SASSLC of being presented plans and actions that occurred just prior to the review only to return six months later and find that efforts only resumed in the weeks just prior to the current review. As a result of this, the facility simply made no progress in this area over a period of several years.	

#	Provision	Assessment of Status	Compliance
		As previously discussed, there were individuals who were actually refusing treatment in clinic who were not documented to refuse treatment. This is a significant concern because these individuals were not being afforded an opportunity to undergo assessment by behavioral health services to determine if they were candidates for any other types of strategies or interventions. The dental director reported that they were re-scheduled with sedation or TIVA. The monitoring team noted in records a pattern that once TIVA was used it was re-scheduled. This was documented in the annual exams and Annual Dental Summaries. There did not appear to be any consideration given to having the individuals assessed by behavioral health services. This was addressed with the dental director during the compliance review and the staff appeared to have a plan moving forward to address this issue. <u>Informed Consent</u> During the week of the monitoring review, the monitoring team reviewed a list of individuals who had signed consents that needed HRC approval. The list included 19 individuals. Seven of the consents were signed in 2013. The long delays in the consent process appeared to have been resolved. The number of individuals with pending approval decreased from 29 observed during the last compliance review. However, continued improvement was needed. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director should address the need to develop a comprehensive dental clinic manual. 2. The facility must address the problems related to reporting clinic data. 3. Individuals who refuse dental treatment should be evaluated by behavioral health services to determine the most appropriate interventions.	

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Section R QA Reports o Current SLPs, license numbers, ASHA numbers, caseloads o Continuing education and training completed by the SLPs since the last review o Facility list of new admissions since the last review o List of individuals with PBSPs o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o List of individuals with behavioral issues and coexisting severe language deficits o List of individuals with PBSPs and replacement behaviors related to communication o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of individuals receiving direct communication-related intervention o List of individuals with communication-related SAPs o Communication Supports Monitoring forms submitted o Summary reports or analyses of monitoring results o Staff training data submitted o Communication Assessments for individuals recently admitted to SASSLC: Individual #305, Individual #290, Individual #338 o Communication Assessments, ISPs, ISPAs, SAPs, intervention plans, IPNs, and other documentation related to communication, including monitoring forms, for the following individuals: • Individual #31, Individual #336, Individual #180, Individual #137, Individual #339, Individual #317, Individual #256, Individual #268, Individual #243, Individual #174, Individual #248, Individual #267, and Individual #80, and Individual #290. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, IHCPs, Pre-ISP Required Attendance sheets, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Hospital Summaries, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38,

	Individual #149, and Individual #154. o PNMP section in Individual Notebooks for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #313, Individual #142, Individual #124, Individual #25, Individual #349, Individual #199, Individual #233, Individual #254, Individual #226, Individual #56, Individual #188, Individual #259, Individual #230, Individual #277, Individual #38, Individual #149, and Individual #154. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director o Allison Block-Trammel, MA, CCC-SLP o Jessica Guerra, MA, CCC-SLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day program areas o ISP for Individual #90
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado Gaitan, MS, CCC-SLP, Habilitation Therapies Director, and lead SLP, Allison Block Trammell, MA, CCC-SLP were the best to date. There were very clear with relevant activities conducted. Actions and self-assessment activities generally corresponded well to the recommendations made by the monitoring team, though not all of elements were addressed and used to determine compliance. Findings were consistently reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. The department leadership and the speech staff were on track to ensure that progress will be made for the next review. Though continued work was needed, the monitoring team acknowledges the work that was accomplished since the last review. The facility rated itself in substantial compliance with R.2 and the monitoring team concurred. SASSLC supported a significant number of individuals with severe

	communication deficits and, as such, it is critical that caseloads be sufficiently smaller to ensure that adequate and appropriate supports are provided. Substantial compliance with R.1 will require the addition of an additional full-time clinician or equivalent to address this. While the actions taken continued demonstrate consistent progress, the monitoring team determined that R.3 and R.4 were not yet in substantial compliance. A focus on staff training related to AAC and communication, as well as, consistency and quality of effectiveness monitoring are indicated. Overall, progress had continued and the plan outlined was a sound one and, combined with the findings of this report, should guide them to make greater strides over the next six months.
	Summary of Monitor's Assessment: There was continued, steady progress in all aspects of provision R and substantial compliance was achieved in R.2. Assessment quality and timeliness had improved and efforts to improve the content of communication assessments were evident. Additionally, there had been a clear effort to work collaboratively with behavioral health to develop communication strategies that were well-integrated into the PBSP and throughout the daily routine. While the collaboration between behavioral health and SLPs was a developing strength, continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. There was a plan currently in place to address this. There were a tremendous number of communication systems in place, including many communication SAPs, though integration of communication supports was not consistently integrated into the ISPs. Though improved, there was insufficient evidence that there was discussion related to the supports provided and their effectiveness. Generally, sections from the communication assessment were inserted into the ISP. There are key aspects of section R that require evidence of integration into the ISP annually and during interim ISPAs. This must include actual documentation that the IDT reviewed the communication dictionary, communication plans, and supports, and that the IDT specifically identified the effectiveness and any need for changes. Based on observations, discussions occurred, but integration must follow through to inclusion in the ISP document and in the implementation of supports and services. All of the SLPs worked diligently to complete assessments and the quality was generally improved. The facility should consider implementation of a peer review process to ensure that all clinicians continue to refine their assessment skills, particularly related to the need for AAC and environmental control. Consistency of documentation of direct supports and review of indirect supports was needed. Effectiveness monitoring should reflect a review of all communication supports rather than only the SAPs. The facility continued to struggle with focusing on what was most meaningful and what were the most fundamental needs of the individual with consistent implementation of SAPs and group activities based on these. Success with this will, in part, require that the speech clinicians lend their creativity by participating on a routine basis to model and infuse communication behavior and interactions in a meaningful way. This is not intuitive for staff, but rather must be taught in real time activities.

	The following samples were used by the monitoring team: • Sample R.1: 17 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services (4) • Sample R.5: Individuals participating in indirect communication SAPs (10)

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Staffing There were three full time SLPs with responsibilities related to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were Allison Block Trammell, MA, CCC-SLP, Jessica Guerra, MA, CCC-SLP, and Roland Hoffmann, MS, CCC-SLP. Ms. Trammell was the lead speech clinician, the SLP representative to the PNMT, and she assumed other administrative duties to assist the departmental director. She estimated her duties related to a communication caseload as 60%. Kathryn Ballance, MS, CCC-SLP, was a part-time contractor (20 hours a week), who worked as assigned. There was a full time speech assistant, until 3/24/14, but there were plans reported to fill that position on 5/1/14. The Habilitation Therapies Director, Margaret Delgado Gaitan, MS, CCC-SLP, was available for direction, clinical assistance, and oversight, but without consistent clinical responsibilities. The facility document that listed budgeted and filled positions identified three budgeted positions for SLPs that were filled at the time of this review. The number of other positions budgeted, such as the SLPA, was not provided. FTEs were calculated as three, with a ratio of 1:79. Based on the list provided for section R related to staffing listed (with two SLPs working approximately half-time related to communication supports and services) and the reported census of 235, the current ratio was approximately 1:78. The SLPA would not be considered as a part of this ratio because assessment was not a permitted scope of her practice, but rather she served a key role to assist and support the SLPs and was licensed to provide direct intervention related to communication. Responsibilities of the full-time communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, attendance at ISPs and ISPAs, and monitoring the implementation of programs related to communication and dysphagia. The full-time SLPs provided supervision to the SLPA, as well as mentoring and training to the Habilitation Therapy technicians to enhance their competency in the monitoring of communication supports and services. The speech staff were assigned caseloads as follows (totals based on individual list by home and based on census of 235):	Noncompliance

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		• Allison Block Trammell: Her part-time communication-related responsibilities included Homes 674 and 766 (approximately 60 individuals) and supervision of the SLPA, as well as, the PNMT and other administrative duties in assistance to the Director. • Jessica Guerra: Her full-time responsibilities included Homes 668, 670, and 673, approximately 93 individuals and supervision of the SLPA. • Roland Hoffmann: His full-time responsibilities included Homes 665, 671, and 672, approximately 83 individuals and supervision of the SLPA. • Kathryn Balance: Her part-time responsibilities were as assigned, primarily completion of assessments, with no specific caseload identified. • SLPA (when filled): Full-time responsibilities included assisting the SLPs as assigned. Per the self-assessment, the facility had identified the need to maintain at least four full-time SLPs and one SLPA based on an anticipated census of 250, of which 185 were expected to have severe communication impairments. There were 174 individuals currently identified with significant communication needs. The Director and Lead SLP presented a very compelling rationale for the need of a fourth full-time SLP, and the monitoring team concurred that three FTE's (including the part-time contract clinician) was not adequate to meet the current communication needs at SASSLC, regardless of whether the current census increased. Staffing had remained generally stable since the previous onsite review, though the SLPA had recently resigned. At three FTEs and one SLPA, SASSLC did not provide an adequate number of speech language pathologists with specialized training or experience to provide communication supports and services based on the process established by the facility. The replacement of the SLPA and the addition of a full-time SLP (State-position or ongoing contract position) would permit the facility to remain within this acceptable ratio for services, based on the existing census. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 4 of 4 speech staff, with responsibilities related to communication (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 4 of 4 speech staff, with responsibilities for communication (100%) held current ASHA certification. This was consistent with the previous review. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review:	

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		• 4 of 4 current speech staff responsible for communication supports and services (100%) had completed continuing education in the last year related to communication in an area that was relevant to the population served. This was consistent with the previous review. Continuing education attended by the clinicians (including the Director) in the last year appeared to be relevant to communication and included the following: • What About Coexisting Issues of Writing in Motor Speech Disorders? A Look at cognitive, Linguistic, and Motor Correlates of Writing with Pen and Technology (4 contact hours) • Augmentative and Alternative Communication for School-Age Children with Intellectual Disabilities: Strategies for Long-Term Intervention (1 contact hour) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (11 contact hours) • Augmentative and Alternative Communication : Using Assessment to Guide Intervention (1.5 contact hours) • Augmentative and Alternative Communication for School-Age Children with Intellectual Disabilities: Basic Strategies for Immediate Results (1 contact hour) • Rehabilitating Your Approach: Maximizing Outcomes in Patients with Cognitive Impairment, Depression, and Dementia (4.5 contact hours) The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to continue to seek continuing education courses beyond in-house training or DADS-sponsored courses to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at SASSLC. There was a local policy related to communication (Revised, 9/11/13). The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services. Each of the following elements was sufficiently addressed in the policy in conjunction with other procedural documents and a well-established procedure was currently in practice: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive	

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		Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an Assessment of Current Status versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. Though the existing staff were well-qualified and experienced, there appeared to be an insufficient allocation of speech staff resources, based on the current census and identified need. The current staff ratio and caseload sizes were high at the time of this review. Limitation to caseload size is critical to ensure that clinicians are able to complete assessments in a timely manner, provide appropriate direct interventions, provide sufficient training, modeling and coaching for the implementation of communication programs, and to adequately maintain the necessary equipment. There was a reasonable process to determine the number of qualified staff required and there were policies and procedures that outlined the roles and responsibilities of the SLPs as described above. The monitoring team concurred with the self-assessment of noncompliance with this provision. In order to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to aggressively recruit at least one fulltime SLP (or retain the current contract staff on an ongoing full-time basis).	
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	<u>Assessment Plan:</u> Assessments were appropriately completed per the ISP schedule, change in status, or per IDT request. By report, all individuals had been provided a Comprehensive Assessment. The facility maintained an evaluation plan which outlined the completion of comprehensive assessments and interim updates, as well as projected subsequent interim updates and comprehensives through 2019. There was a tracking log of assessments completed from 8/16/13 through 3/7/14. As noted previously, the SLPs at SASSLC completed a Comprehensive Communication Evaluation and/or an Assessment of Current Status. At the time of this review, some changes had been made to the standard format for these reports per the state office and	Substantial Compliance

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	interventions.	were in use as of 10/1/13. All individuals newly admitted to SASSLC were to be provided a comprehensive assessment of communication completed within 30 days of admission. All individuals were to be provided a Comprehensive Assessment at least every five years, unless there was a significant change in status or special IDT request. Individuals who had a communication device received a comprehensive assessment every three years. An Assessment of Current Status was to be provided annually in the interim for individuals who received both direct and indirect services in years that a Comprehensive Evaluation was not required. Assessment due dates and timeliness of completion were maintained in the tracking log for individuals with ISPs scheduled from 9/3/13 through 3/26/14. Overall, per the self-assessment, there were 113 assessments completed from 9/1/13 through 2/28/14. Of these, 103 were reported to be on time, 10 days prior to the ISP, 91% overall. In the last five months, timeliness was reported to average 97%. <u>Assessments Provided</u> Communication assessments for individuals in Samples R.1 (17 individuals) and R.4 (four individuals) were submitted as requested for the following: Comprehensive Communication Assessment 1. Individual #199 (6/6/13) 2. Individual #25 (1/17/12) 3. Individual #124 (3/26/13) 4. Individual #142 (1/14/13) 5. Individual #313 (10/9/12) 6. Individual #38 (6/18/11) 7. Individual #149 (2/11/13) 8. Individual #230 (9/9/11) 9. Individual #154 (7/15/12) 10. Individual #259 (4/20/12) 11. Individual #188 (7/5/13) 12. Individual #56 (6/6/11) 13. Individual #226 (2/14/13) 14. Individual #254 (12/13/12) 15. Individual #233 (6/12/13) 16. Individual #336 (10/5/12) 17. Individual #31 (1/22/14) 18. Individual #180 (2/2/12) 19. Individual #290 (2/5/14)	

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		Interim Communication Update 1. Individual #38 (6/18/13) 2. Individual #154 (6/21/13) 3. Individual #230 (9/3/13) 4. Individual #56 (5/21/13) 5. Individual #313 (10/1/13) 6. Individual #336 (9/25/13) 7. Individual #180 (1/10/13) Speech Language/Communication Assessment of Current Status 1. Individual #199 (3/5/14) 2. Individual #349 (11/18/13) 3. Individual #25 (1/15/14) 4. Individual #124 (3/19/14) 5. Individual #149 (2/18/14) 6. Individual #259 (3/26/14) 7. Individual #226 (2/10/14) 8. Individual #254 (11/24/13) 9. Individual #180 (1/10/14) • 19 of 20 individuals (95%) in Samples R.1 and R.4, who received direct and/or indirect communication supports and services, were provided an assessment or update current within the last 12 months. No assessment was indicated for Individual #142, he demonstrated communication skills and did not receive supports or services. No assessments were submitted for Individual #277. • 4 of 4 individuals admitted since the last review (100%) received a communication assessment within 30 days of admission. This was consistent with the previous review. • For 17 of 20 individuals (85%) in Samples R.1 and R.4, the most current assessments or updates were dated as having been completed at least 10 working days prior to the annual ISP. This was an improvement from 44% in the previous review. No assessments were submitted for Individual #277. In the case of Individual #149, her most current ISP was not in her individual record and was not submitted. The timeliness was calculated from the tracking log data and it appeared to be on time. The following assessments were not completed 10 working days prior to the ISP: Individual #188, Individual #124, and Individual #154. Each of these was completed prior to the ISP. Per the self-assessment, timely submission was at 90% for the last five months. • The following metric was not applied because SASSLC did not complete	

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		communication screenings at the time of this review. For --% of individuals identified with communication needs through a screening, a comprehensive communication assessment was completed within 30 days of identification. Based on review of the assessments submitted and included in Samples R.1 and R.4 (20 individuals), there were only four individuals with comprehensive assessments completed within the last 12 months (Individual #31, Individual #188, Individual #233, and Individual #290). Only two had been completed since the implementation of the most current format implemented in October 2013 (Individual #31 and Individual #290). As such, the other three assessments completed earlier than 10/1/13 were not included for review. Five current assessments for each clinician were requested for review. Five were submitted for Allison Block Trammell, Jessica Guerra, and Ron Hoffmann with one only for Kathryn Ballance. All but one was a comprehensive assessment (Individual #234), though the assessment for Individual #31 was duplicated in Sample R.4. Of the 15 comprehensive assessments submitted, 11 had been completed after 10/1/13. The other 10 were included in the sample for review and analysis below for a total of 12. The current state and local SASSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the comprehensive communication assessments was as follows: • 12 of 12 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. • 12 of 12 assessments (100%) included diagnoses and relevance of impact on communication. This was consistent with the previous review. • 12 of 12 assessments (100%) included individual preferences and strengths. Ideas for how to integrate preferences into communication opportunities were a notable strength of these assessments. This was consistent with the previous review. • 12 of 12 assessments (100%) included medical history and relevance to communication. The medical history reported was extensive with limited analysis of the relevance to communication, though this was clearly stated relative to the current diagnoses. This was consistent with the previous review. • 12 of 12 assessments (100%) listed medications and discussed side effects relevant to communication. This was consistent with the previous review. • 12 of 12 assessments (100%) provided documentation of how the individual's communication abilities impacted his/her risk levels. Risk areas were comprehensively presented with OT and PT, but the relationship with communication was not offered. This was an improvement from 40%. • 12 of 12 assessments (100%) incorporated a description of verbal and	

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		nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was consistent with the previous review. • 11 of 12 assessments (92%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). One assessment was conducted during a hearing evaluation and on the phone (Individual #263). While these settings were appropriate for some level of assessment, these settings did not meet criteria of natural and familiar. This was a decrease from 100% in the previous review. • 5 of 5 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 changes as required. This was not indicated for four individuals. This was consistent with the previous review. • 8 of 9 individuals' communication assessments (89%) included discussion of the expansion of the individuals' current abilities. This was an improvement from 78% in the previous review. • 8 of 9 individuals' communication assessments (89%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 56% in the previous review. • 4 of 4 assessments (100%) included the effectiveness of current supports, including monitoring findings. These did not consistently address specific monitoring findings, but rather more generally. This was an improvement from 0% in the previous review. • 6 of 6 assessments (100%) assessed AAC needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC. It was noted, however, that in the case of Individual #7, Environmental Control was deemed not necessary without sufficient assessment. This was consistent with the previous review. • 12 of 12 assessments (100%) offered a comparative analysis of health and functional status from the previous year. Two of these were for individuals who were newly admitted so this information was limited. This was consistent with the previous review. • 12 of 12 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was consistent with the previous review. • 12 of 12 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was consistent with the previous review. • 9 of 12 assessments (75%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was a decrease from 100% in the previous review. In the three cases in which this was omitted,	

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		the individuals were verbal, without a need for specific communication supports. The facility should consider that recommendations for effective communication strategies may be needed for individuals who were verbal. In case deemed to be unnecessary, this should be stated with a rationale. • 12 of 12 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 5 of 5 assessments (100%) supplied a monitoring schedule. This was consistent with the previous review. • 7 of 8 assessments (88%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was a decrease from 100% in the previous review. • 12 of 12 assessments (100%) made a recommendation about community referral and transition. It was noted that a specific statement related to community placement was not made in many assessments, but rather this was inferred when the clinician stated that no communication supports were needed in the community. The clinician's opinion should be clearly stated in each assessment. This was consistent with the previous review. • 12 of 12 assessments (100%) included specific recommendations for services and supports in the community. This was consistent with the previous review. • 12 of 12 assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was consistent with the previous review. Additional findings related to the communication assessments were as follows: • 8 of 12 assessments (67%) contained 100% of the 23 elements listed above. Previously this was found for only 40% of assessments reviewed. • 10 of 12 assessments (83%) contained 94% or more of the essential elements listed. • Two assessments were slightly below 90%. • Additionally, 18 of 23 (78%) elements were present in 100% of the assessments. Three others were above or very near the established 90% criterion and considered in compliance, while one was at 75%. That element related to the provision of specific and individualized strategies to ensure consistency of implementation among various staff. In the three cases, in which this was omitted, the individuals were verbal, without a need for specific communication supports and these were likely considered to be unnecessary. The facility should consider that recommendations for effective communication strategies may be needed for individuals who were verbal. • The average for all 12 assessments was 95%. • There was a decrease across three elements. Improvements were noted for four	

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		elements, while the others remained consistent with the previous review at 100%. It was reported that 28 assessments had been completed from 9/1/13 through 2/28/14 and 20 of those (first drafts) had been audited (self-assessment, page 24). It was reported that 75% of the first drafts were 90% compliant with the required elements and that 100% of the final drafts included at least 90% of the required elements. Updates or Assessments of Current Status (ACS) were submitted for 14 individuals included in Samples R.1 and R.4. • 14 of 14 updates (100%) were completed consistent with the established schedule, the individuals' need, and/or previous recommendations, and the associated comprehensive assessment was present in the individual record. For five individuals (Individual #259, Individual #38, Individual #230, Individual #25, and Individual #56), only the comprehensive and the most current update were noted in the individual records. The Master Plan indicated that each interim update subsequent to the comprehensive assessment had been completed as required, but they were not contained in the individual records. The Assessments of Current Status (the most current format for annual updates) included the following minimum requirements: • The individual's current status • Description of the interventions that were provided • Effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year • Monitoring and re-assessment schedules. It was noted that specific findings from monitoring that occurred over the previous year were not consistently addressed in the Assessments of Current Status, however. <u>SLP and Behavioral health Collaboration:</u> There were 105 individuals identified with behavioral issues and co-existing severe (nonverbal or limited verbal skills). There were 61 individuals listed with PBSPs who also had replacement behaviors related to communication. At least 10 individuals in Sample R.1 were listed with a PBSP. Six of these were current. The others were not current within the last 12 months (Individual #149 and Individual #142) and there was no PBSP in the record for Individual #154. There was only a plan for continued use of a Protective Mechanical Restraint (abdominal binder) for Individual #199. Based on review of these, the following was noted:	

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		• For 5 of 6 communication assessments (83%) in Sample R.1 for individuals with identified challenging behaviors, there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section. This was an improvement from 44% in the previous review. There was no discussion of current Behavioral Considerations in the update for Individual #56 (5/21/13) or the comprehensive completed on 6/6/11, though these were older formats. Moving forward it was expected that all assessments would contain this. • 5 of 6 communication assessments and PBSPs reviewed (83%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • 5 of 6 communication assessment reviewed (83%) contained evidence of review of the PBSP by the SLP. • For 5 of 6 individual (83%), communication strategies identified in the assessment were included in the PBSP. There was no identification of a hearing loss for Individual #349 in the PBSP. Others did not include the communication strategies outlined in the assessment, but were not inconsistent. In the case of Individual #259, the AAC device provided to him was referenced. There was a current plan in place to ensure that the communication strategies outlined in the communication assessment would be attached to all PBSPs. • For % of individuals (NA), communication strategies related to behavior identified in the assessment were included in the ISP. The ISP and PBSP for Individual #259 were to expire on 4/30/14 and did not match the most current communication assessment, which indicated that, because behavior concerns had decreased, he would no longer require a PBSP. This could not be confirmed based on the documents submitted. As described above, the communication assessment for Individual #56 did not address the PBSP. The target behaviors for the others were not identified as communication-based. Integration of communication strategies into the ISP is addressed below in R.3. Minutes for meetings held to review PBSPs during the last six months were submitted. • Based on review of the Behavior Therapy Committee (BTC) meeting sign-in sheets from 9/3/13 through 2/24/14, participation by a SLP or SLPA was noted in 21 of 21 meetings (100%). It was not clear if all sign-in sheets were submitted or only those with an SLP in attendance. The self-assessment reported that there were that there had been 24 meetings between 9/1/13 and 2/28/14 for which attendance by an SLP was documented to be 23 of 24 or 96%). Actual meeting minutes were not submitted. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between behavioral health and the speech staff. There was	

#	Provision	Assessment of Status	Compliance
		significant effort to develop collaborative replacement behavior goals related to communication. Though these were co-developed, it was not clear that progress with these was reviewed by the SLPs throughout the year. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts. Continued effort is needed to ensure that there is sufficient coordination of supports, services, and communication methods. There may be other means to accomplish this beyond the PBSP meetings, such as the pre-ISP planning and during the assessment process. The communication assessment generally reported communication with behavioral health related to the interpretation of the functions of target behaviors and whether there was a communication component. Evidence of additional efforts should be documented and evident in the supports and services developed. The facility self-rated this provision in substantial compliance, and the monitoring team concurred based on the findings reported above. Further coaching and monitoring of speech clinicians will be necessary to maintain compliance with the essential elements for communication assessments. In several cases, the assessments were written using similar or very near similar content and wording and this should be avoided.	
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.	<u>Integration of Communication in the ISP:</u> Attendance at the annual ISPs for individuals was reviewed. The ISP submitted for Individual #149 was not current within the last 12 months. The ISP for Individual #259 was dated 4/30/13 and did not reflect the recommendations from the most current communication assessment dated 3/26/14. Pre-ISP required attendance sheets were not submitted for the following individuals: Individual #226, Individual #154, Individual #277, Individual #336, Individual #31, Individual #180, Individual #290, Individual #199, Individual #25, Individual #142 and Individual #233. • For 7 of 8 individuals in Samples R.1 and R.4 (88%), a SLP was in attendance at the ISP as designated by the pre-ISP. Required attendance at the ISP for Individual #254 was not clear, per the copy submitted. The ISP for Individual #259 was dated 4/30/13 and did not reflect the recommendations from the most current communication assessment dated 3/26/14. Though a pre-ISP required attendance sheet was not submitted for Individual #142, SLP participation in his ISP was not likely indicated based on his communication abilities and an SLP did not attend that meetings. No SLP attended the ISP for Individual #25, though a Habilitation Therapies representative was present. As there was no pre-ISP available it could not be determined if this had been as designated by the IDT. In the other eight cases with no pre-ISP available, an SLP attended all of the ISP meetings for those individuals with the exception of Individual #154 and Individual #233. Communication-related SAPs and other	Noncompliance

#	Provision	Assessment of Status	Compliance
		communication supports had been recommended for them indicating a need for SLP participation in their ISPs. • For 12 of 20 individuals (60%), communication strategies identified in the assessment were included in the ISP. The ISP for Individual #259 was dated 4/30/13 and did not reflect the recommendations from the most current communication assessment dated 3/26/14. No specific strategies were identified in the assessment for Individual #233. Strategies for Individual #277 were included in his ISP, though no assessments were noted in his record. • In 11 of 18 ISPs for individuals with communication supports (61%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, and strategies for staff use) were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 50%, as evidenced in the ISP. Some only mentioned the dictionary as a support, but did not reflect IDT review. • 17 of 20 ISPs (90%) included a description of how the individual communicated, though some provided a very limited description. • 14 of 20 ISPs (70%) contained skill acquisition programs to promote communication. Some identified the need for SAPs, but these were not translated to the ISP action steps. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was not addressed in the ISPs reviewed. This element of this provision was greatly improved. Though there was evidence that the IDT discussed communication, some did not clearly outline that the dictionary was reviewed and that modifications were or were not required. Most had an improved summary of how the individual communicated and how staff should communicate with them. This will not always be sufficiently reflected in the paragraphs selected from the speech assessment, though these issues should be addressed by the team and reflected in the narrative of the ISP. The communication strategies outlined in the communication assessments were generally very good and highly individualized. Consistent integration of these into the ISP would be a useful practice. The Habilitation Therapies Director collaborated with the QIDP Coordinator to address these problems in the ISPs. <u>Individual-Specific AAC Systems:</u> As of 3/7/14, there were 174 individuals living at SASSLC who presented with severe communication deficits. By report, 161, or 93%, of these had been provided an AAC device and/or a SAP to address their communication deficit. These systems were generally portable, functional, and individualized. Individualized AAC device instructions were developed in most cases to provide a picture of the device and to clearly outline the	

#	Provision	Assessment of Status	Compliance
		purpose with staff instructions for use and care of the device. There were four individuals listed as participating in direct communication therapy intervention at the time of this review. Twenty individuals were listed with environmental control devices. A number of individual systems were observed during this review. A number of these appeared to be excellent and were designed to integrate meaningful communication opportunities for individuals integrated into their daily routine. As in previous reviews, actual consistent implementation and maintenance of the devices continued to be a struggle. Communication dictionaries (CD) were also provided to at least 161 individuals. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This should enhance staff understanding of the individual and promote consistent responses, but does not specifically improve the individual's expressive or receptive skills. Changes needed to the CDs were not specifically outlined in the ISP. In some cases, changes were stated as needed, but not specifically outlined, even in the communication assessment. The following metric could not be determined: • --% of individuals for whom the IDT directed a revision in the communication dictionary, the communication dictionary was revised within 30 days. Many of the assessments for the individuals in Sample R.1 and R.4 reviewed above provided an adequate assessment of the individual's potential for AAC use, though continued improvements may be promoted through the use of peer review. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings, such as to request a favorite item, food, beverage, music, vibration, or massage. In some cases, the assessments reported that a device was tried with an individual, but when they did not spontaneously use it, the device was dismissed as a viable option. Specific efforts to promote practice and use in the natural environment should be identified for those individuals within the environmental communication efforts outlined above. This has been identified by the monitoring team in previous reviews. <u>General Use AAC Devices:</u> There were a number of general use devices noted in many homes. All of the systems noted during this onsite review were operational, and had a clear function within the environment, though none were seen in use. Directions were not necessarily posted, though use of these was competency-trained in NEO.	

#	Provision	Assessment of Status	Compliance
		Direct Communication Interventions: There were only four individuals listed as participating in direct communication-related interventions provided by the SLP (Individual #31, Individual #336, Individual #180, and Individual #290). Records related to the provision of direct intervention for these individuals were reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • For 4 of 4 individuals (100%), a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. • For 4 of 4 individuals (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 3 of 4 individuals (75%), there were measurable objectives related to individual functional communication outcomes included in the ISP. The identified SAP objective was not included as an action in the ISP for Individual #180. The SAP indicated that she would activate her AAC device with one verbal prompt, but the task analysis did not indicate if she needed a verbal prompt. • For 3 of 4 individuals (75%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). In the case of Individual #180, the notations for March 2014 did not match the data reported. The data indicated that she met criteria 1 of 4 trials, but the monthly note indicated that she had met criteria for 4 of 4 trials. There was no evidence of documentation to date in April 2014 through the time of this review for any of the individuals included in Sample R.4. • For 4 of 4 individuals (100%), there was a description of the benefit of the device and/or goal to the individual in the progress notes and/or monthly summaries. • For 4 of 4 individuals (67%), consistency of implementation was documented. • For 4 of 4 individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. The clinician should consider a review of the strategies to determine if any changes could be made to address inconsistent progress in the case of Individual #336. • For --% of individuals for whom direct intervention had been discontinued (NA), termination of the intervention was well justified and clearly documented in a timely manner. • 3 of 4 (75%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the	

#	Provision	Assessment of Status	Compliance
		generally accepted indicators listed below (Individual #31): ○ Contained information regarding whether the individual showed progress with the stated goal. ○ Described the benefit of device and/or goal to the individual. ○ Reported the consistency of implementation. ○ Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. ○ Completed at least monthly. Data collection was addressed for each session. A monthly notation summarized overall progress for the month. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication plans, communication dictionaries, general use AAC, and communication-related SAPs. AAC supports were identified in the annual assessment and described in the PNMP and, in some cases, individual communication plans, including pictures of specific devices as indicated. Other indirect supports were developed in the form of SAPs implemented by DSPs in the home, day program, or work areas. There were a significant number of SAPs developed for replacement behaviors, with SLP involvement in the development of these and in routine monitoring. By report, 90 of 90 individuals assessed between 9/1/13 through 2/28/14 who presented with severe communication deficits were provided a communication-related SAP, per the self-assessment. SLPs are also encouraged to work closely with the program developers on new or existing SAPs (not only those related to communication) to ensure that communication strategies are well integrated into these plans. The challenge moving forward is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching. These were recommended for effectiveness monitoring by the SLPs on a specific schedule though this appeared to be inconsistent. See R.4 below. Documentation for 10 of 10 individuals who received indirect communication supports (SAPs) included the following elements: • Implementation within 30 days of the plan's creation (typically as of the ISP or ISPA), or sooner as required by the individual's health or safety. • The current SLP assessment should clearly identify the need for indirect intervention with rationale. This was consistently noted for the assessments completed and reviewed. • Measurable objectives related to individual functional communication outcomes to be achieved through indirect intervention should be included in the ISP.	

#	Provision	Assessment of Status	Compliance
		• Staff instructions provided for individuals' AAC devices, including written step-by-step instructions and pictures. <u>Competency-Based Training and Performance Check-offs:</u> SASSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Based on the schedule submitted, class time included approximately 2.25 hours to address deaf awareness and AAC. This was significantly less than the time allowed for other PNM-related issues. Communication is an issue shared by all individuals and a key element to the successful provision of all supports provided by staff. As such, significant time is needed to provide instruction. The topics, based on review of the curriculum materials, were comprehensive, though time frames for presentation were extremely limited. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. New employees were given approximately 10 minutes to practice. This approach would appear to be somewhat biased. Then, new employees were required to take a combination of written tests and were checked-off on specific skills, using the checklists. Return demonstration was required for each skill. Competency check-off forms were used to establish participants' abilities to use object rings, recognize nonverbal communication, reference a communication dictionary, switch set-up, use an appropriate prompt sequence, use of a Voice Output device, and basic sign language. Employees were expected to pass all essential elements of the core competencies. The legitimacy of competency testing was likely limited given the timeframe permitted. Check-off stations were established by the PNMPCs for additional check-offs. Shadowing was then conducted prior to new employees being permitted to work independently on their assigned homes. They were not assigned a caseload, but were allowed to assist existing staff in the implementation of foundational skills in that home. During that time, staff were to receive on-the-job trained related to the PNMPs and Dining Plans on the assigned home, as well as on individual-specific (non-foundational skills) competencies, generally by the PNMPCs.	

#	Provision	Assessment of Status	Compliance
		• 100% of the 122 staff completed NEO core communication training (i.e., foundational skills) and passed performance check-offs since the last review, based on the participation reports. • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs was submitted. A four-hour refresher training was developed in the area of communication/AAC and was implemented. This included a number of the competency check-offs used in the NEO training described above. Again, the training contained good content, but the time available for instruction and practice was very limited. • 159/159 (100%) of staff required to take the Annual Refresher class related to communication successfully passed the competency check-offs. • There was a system to establish and maintain competency for staff who provided the training. A sample packet of information to demonstrate the extent of the check-offs required for validation of staff who conducted training and check-offs. <u>Individual-Specific Competency-Based Training</u> Non-foundational training was provided by Habilitation Therapy staff in the case that a required element of the individual's plan was not included as a core competency in the NEO/refresher training curriculum. This type of training required competency check-offs in order that staff could implement that element. There were no individuals identified with non-foundational components related to communication. The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. • Per the system in place, 100% of the staff assigned to individuals were trained related to individualized communication plans prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals had completed competency check-offs in all specialized components of their communication plans (i.e., non-foundational skills) prior to provision of services. • The facility had a process to validate that staff responsible for training other staff were competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though significantly improved, there was insufficient integration of communication supports and services into the ISP and inconsistencies related	

#	Provision	Assessment of Status	Compliance
		documentation of direct therapy. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure that the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and consistent with the individual's communication function and methods of communication. 2. Ensure that information related to communication was effectively translated to the ISP. 3. Address the consistency and necessary elements of documentation of direct interventions.	
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.	<u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at SASSLC using the Communication Supports Monitoring Tool. This form addressed the following: • Plan was current and available. • Equipment was available. • Equipment was in good condition. • Implementation as per the plan. • When equipment was used, staff responded. • Staff accurately described or demonstrated how the device or objective should be implemented. Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1 with communication supports (17 individuals). Forms were submitted for each with the exception of Individual #154. Compliance monitoring frequency was listed as follows: • Ten times per year for Individual #38. • Eight times per year for Individual #313, Individual #226, and Individual #259. • Quarterly for Individual #230 and Individual #199. • Compliance monitoring was designated as not needed for Individual #142 and Individual #254. • There was no designation for compliance monitoring eight individuals, though most were recommended for SAP effectiveness monitoring. • There was no assessment submitted for Individual #277. • Monitoring appeared to be conducted as recommended for 15 of 17 individuals (exceptions included Individual #149 and Individual #313). • In two cases, monitoring was attempted at the time the individual was in the hospital and this was clearly indicated on the form (Individual #259 on 1/14/14	Noncompliance

#	Provision	Assessment of Status	Compliance
		and Individual #149 on 1/31/14). There was no evidence that this had been repeated as of the time of this onsite review. The monitoring schedule should require that the monitors not merely attempt to do the monitoring, but actually complete it as per the established interval. Twelve forms for seven individuals were submitted. Six of these forms were compliance monitoring only and the other six also included effectiveness monitoring completed by the SLP. Upon review of the forms submitted for the individuals in Sample R.1, the following was noted: • Five of these forms indicated that the equipment was not working or had dead batteries. • In one case, the monitor reported that the batteries were dead, yet marked that the device and objective were observed to be implemented per the plan (Individual #230 on 2/28/14). If batteries are dead, the individual does not have access to the device and, as such, the indicators pertaining to access and implementation should be marked "no." • In another case, the batteries were identified as dead, but the implementation indicators were marked as "NA" rather than "No" (Individual #259 on 2/26/14). • Other indicators were marked as in compliance. Compliance monitoring should be conducted routinely to address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Compliance monitoring appeared to be conducted at the assigned frequency. Follow-up was clearly documented on the forms submitted, though on 2/26/14 in the case of Individual #259, the monitor indicated that the observation should be repeated, but there was no evidence of this. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. This aspect may require additional monitoring to track the working condition of individual and general user devices on at least a monthly basis. Communication dictionaries should be monitored for availability, effectiveness, and whether staff understand how to use them. This did not appear to be done. Per the self-assessment: • From 9/1/13 to 2/28/14, communication error ratios were not within the goal of 20% or less, ranging from 24% to 36%; reduced from 39% since July 2013. • Sample size ranged from 87 to 113 depending on the number of monitoring tools completed each month.	

#	Provision	Assessment of Status	Compliance

		• Communication Plan availability had improved, but was likely attributed to a change in the standard for this element. At this time, as long as the plan was not locked up, but available in the same building as the individual, this was marked in compliance.
		• Other improvements were noted in the presence, accessibility, and implementation of AAC.
		• CAPs had been implemented to address the following from 11/1/13 through 2/28/14:
		  ○ Availability of Communication Plans in two homes
		  ○ Communication device implementation in one home
		  ○ Implementation of a device for two individuals
		  ○ Staff knowledge of communication supports in one home
		  ○ Trend of devices not working in two homes
		
		<u>Effectiveness Monitoring</u>
		This type of monitoring should address communication plans and AAC, dictionaries, and SAPs related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment. This should address any changes in risk or health and functional status of the individual since the previous review, staff compliance, as well as, whether the supports and/or strategies effectively met the intended need. Frequency of these should be included in the ISP with documentation in the individual record. Documentation should include the following:
		• Previously unresolved issues
		• PNM Risk occurrences since the previous effectiveness monitoring that impact communication
		• Purpose and function of the device or support
		• Presence and condition of equipment
		• Staff knowledge and compliance, consistency of implementation
		• Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate
		• Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion
		
		At SASSLC, the Communication Supports Monitoring Tool was used for effectiveness monitoring and paired with compliance monitoring. It did not appear that SASSLC included the annual assessment as one of the required monitorings each year. The current form appeared to oversimplify this process, with some clinicians using one word responses, rather than analysis of findings and it did not address each of the elements	

#	Provision	Assessment of Status	Compliance
		listed above. Effectiveness monitoring completed for the last six months was requested. The effectiveness monitoring forms submitted for R.1 (six for five individuals) and R.5 (10 for 10 individuals) appeared to focus only on the SAPs that provided indirect communication supports, rather than all aspects of the individual's communication supports. The frequency of effectiveness monitoring was recommended in the communication assessment for individuals in Sample R.1 as follows: • Twice yearly for Individual #124, Individual #25, Individual #349, Individual #233, Individual #56, Individual #188, and Individual #154. • Quarterly for Individual #313, Individual #199, Individual #226, Individual #259, Individual #230, Individual #38, and Individual #149. • Effectiveness monitoring was not required for Individual #142 and Individual #254 per their communication assessments. Based on the tools submitted, monitoring had occurred quarterly as required for Individual #226, Individual #259, Individual #230, and Individual #38. There was no evidence of quarterly monitoring for Individual #313, Individual #199, or Individual #149, who should have been monitored twice in the last six months. There was no evidence of any other monitoring for the other individuals in the sample reviewed. There was a significant lack of consistency related to the completion of these for individuals who were provided communication supports and there was a lack of consistent reference to these findings in the communication assessments reviewed. The facility concluded that they were not in compliance with this provision of section R, and the monitoring team concurred as described above. The self-assessment identified that monitoring had been conducted per the established schedule, but document submissions did not support that. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines to enhance consistency. Consider use of an IPN to further document these findings. 2. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment or other established guidelines. Ensure that these findings are included in annual communication assessments for individuals.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plan (ISPs) for: • Individual #173, Individual #116, Individual #160, Individual #280, Individual #128, Individual #291 Individual #55, Individual #120, Individual #119, Individual #283, Individual #305, Individual #285, Individual #167, Individual #349, Individual #203, Individual #279, Individual #122 o Skill Acquisition Plans (SAPs) for: • Individual #287, Individual #64, Individual #268, Individual #304, Individual #173, Individual #116, Individual #160, Individual #280, Individual #128, Individual #222, Individual #169, Individual #178, Individual #12, Individual #117 o Monthly reviews of SAP data for: • Individual #280, Individual #116, Individual #128 o Functional Skills Assessments (FSA) for: • Individual #173, Individual #116, Individual #160, Individual #280, Individual #128 o Preferences & Strengths Inventory (PSI) for: • Individual #116, Individual #280, Individual #128, Individual #160 o Vocational assessments for: • Individual #173, Individual #128 o Public transportation assessments for: • Individual #173 o Sensory Skills Assessment for: • Individual #116 o Retirement Program Assessment for: • Individual #280 o Dental Desensitization procedures/guidelines, undated o Engagement data for March 2014 o Skills Acquisition Observation Tool, undated o List of on-campus and off-campus day and work programs, undated o List of individuals employed on and off campus, undated o Graph of the percentage of graphed SAPs from March 2013- March 2014 o Skill Acquisition Monitoring data for February 2014 and March 2014 o Chart of the percentage of individuals with severe communication deficits that have a communication SAP o Community activity data for all homes for February 2014 and March 2014 o Training in the community data for February 2013 and March 2014

	○ Public Transportation Assessment, undated ○ Skill Acquisition observation tool, undated ○ Resident Engagement form, 2/20/14 ○ Section S self-Assessment, 4/17/14 ○ Section S action plan, 4/17/14 ○ Section S presentation book, undated ○ List of individuals under age 22 and their educational placement/status ○ ISPs, ARD/IEPs, public school report cards and progress notes, and ISPAs indicating QIDP and IDT review of these reports for: • Individual #122, Individual #279, Individual #203 <u>Interviews and Meetings Held</u>: ○ Gina Dobberstein, Music, Recreation, and Senior Program Director ○ Dr. Alvydas, Dentist; Amy Jo Hush, Dental Hygienist; Charlotte Fisher, Director of Behavioral Health Services; Gina Dobberstein, Music, Recreation, and Senior Program Director ○ Eric Saenz and Carlos Rodriguez, QIDP liaisons with SAISD <u>Observations Conducted</u>: ○ ISPA Preparation meeting for: • Individual #255 ○ Active treatment meeting ○ SAP implantation/monitoring for: • Individual #178
	Facility Self-Assessment: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be based directly on the monitoring team's report. SASSLC's self-assessment consistently included a review, for each provision item, of the activities engaged in by the facility, the topics that the monitoring team commented upon in the last report, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This allowed the facility and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of SASSLC in completing the self-assessment, and believes that the facility was proceeding in the right direction. SASSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings. The self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur throughout the facility, and

	because it will likely take some time for SASSLC to make these changes, the monitoring team recommends that the facility establish, and focus its activities on, selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, the monitoring team noted several improvements since the last review. These included: • Improvements in the quality of SAPs reviewed (S1) • Individualized targeted engagement levels were achieved in 52% of treatment sites in March 2014 (S1) • Initiated dental desensitization plans (S1) • Improvement in the engagement tool (S1) • Development of a public transportation assessment (S2) • Increased percentage of graphed SAP data (S3) • Development of program change forms to document data-based decisions to continue, discontinue, or modify SAPs (S3) • Expansion of the collection of SAP treatment integrity data to the residences (S3) • Established individualized recreational and community training goals for all residences (S3) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that all SAPs contain clear examples of all the components necessary for learning discussed in the report (S1) • Develop a system (e.g., spreadsheet) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams (S1) • Ensure that all individuals have assessments of preferences and strengths (S2) • Provide documentation that assessments are completed and available to team members at least 10 days prior to each individual's ISP (S2) • Expand the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans to all individuals at SASSLC (S2) • Ensure that all individuals have monthly graphed summaries of SAP performance (S3) • Consistently use program change forms to document the use of data-based decisions to continue, discontinue, or modify SAPs (S3) • Ensure that SAP treatment integrity includes a direct observation of DCPs implementing the plan (S3) • Establish acceptable treatment integrity levels (S3) • Demonstrate that established goal levels of individuals participating in community activities and training are achieved (S3)

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SASSLC. Although there was progress since the last review, more work (discussed in detail below) is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at SASSLC had multiple skill acquisition plans. Skill acquisition plans (SAPs) at SASSLC consisted of training objectives. The majority of SAPs were written and monitored by the music, recreation, and senior program director, active treatment coordinators, and active treatment specialists. Vocational coordinators wrote and monitored vocational SAPS. SAPs were implemented by direct support professionals (DSPs), rehabilitation assistants, and active treatment specialists. An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preferences. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. As discussed in previous reports, SASSLC modified the SAP training sheet/format to include a rationale for the SAP. The purpose of including the rationale on each SAP training sheet was to encourage staff to ensure that the plan was functional and practical for that individual. The monitoring team reviewed 38 SAPs across 14 individuals to assess compliance with this provision item. In 30 the 38 SAPs reviewed (79%), the rationale appeared to be based on a functional need and/or preference. This is an improvement over the last review when 74% of SAPs were judged to have a clear rationale. It is also consistent with the facility's self-assessment, which indicated that 80% of their sample of SAPs had clear rationales. The following are examples of rationales that were judged to be based on a functional need and/or preference: • The rationale for Individual #173's SAP to name four emergency contacts said he independently rode the bus and the treatment team determined that he needed to know the emergency contacts if he needed assistance • The rationale for Individual #116's SAP of turning on the radio indicated that it was developed because the team determined she needed to improve her communication skills	Noncompliance

#	Provision	Assessment of Status	Compliance
		On the other hand, some rationales simply indicated that SAPs were recommended in the ISP or FSA, but were judged to not be specific enough for the reader to determine if the recommendation was based a functional need and/or preference. For example: • The rationale for Individual #160's SAP of folding laundry said the functional skill assessment (FSA) indicated that she did not have the skill. It was not apparent that folding laundry was a preference or represented a need for Individual #160. The fact that someone can't do something is not a rationale for having a SAP. A rationale should be based on a functional need and/or preference. SASSLC should ensure that each SAP contains a clear rationale for its selection. Additionally, the rationale should be specific enough for the reader to understand that the SAP was practical and functional for that individual. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology All SAP training sheets contained all of the above components. The quality of some of these components continued to improve, however continued to need work. The maintenance and generalization plans were improved compared to the last review. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Thirty-two of the 38 SAPs reviewed (84%) included a plan for	

#	Provision	Assessment of Status	Compliance
		generalization that was consistent with the above definition. This was an improvement over the last review when 76% of generalization plans were judged to be consistent with the above definition. Additionally, 31 of the 38 SAPS reviewed (82%) included a plan for maintenance that was consistent with the above definition. This represented a sharp increase from the last review when only 63% of the maintenance plans reviewed were judged to be consistent with the above plan. An example of a generalization plan judged to be consistent with the above definition was: • The plan for generalization in Individual #173's SAP of staying on task said this skill would be generalized to staying on task to for other vocational activities and task completions at home, such as washing clothes, etc. Some generalization plans, however, were unclear or judged to be too vague to be useful to foster generalization of new skills. An example of an unacceptable plan for generalization was: • The plan for generalization in Individual #116's SAP to brush her teeth said brushing her teeth would help improve her health An example of a good maintenance plan was: • The plan for maintenance in Individual #128's SAP of making purchases in community indicated that once he had mastered this SAP he would continue to make community purchases to maintain the new skill An example of an unacceptable maintenance plan was: • The plan for maintenance in Individual #280's SAP to use a switch to request snacks said that he will be trained to use this device to request other wants It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. Additionally, the quality of several other components listed above was unacceptable. For example: • The consequence for an incorrect response was sometimes unclear (e.g., Individual #173 's SAP to identify drug side effects, Individual #178's hand washing SAP, etc.) • The teaching descriptions were sometimes unclear (e.g., Individual #64's SAP to sit in the dentist chair; Individual #178's hand washing SAP) At the time of the onsite review, the facility used various training methodologies,	

#	Provision	Assessment of Status	Compliance
		including total task training and forward and backward chaining. As discussed in the last report, however, additional training and monitoring of SAPs at SASSLC was necessary to ensure that they were implemented and documented as written (see S3). Overall the monitoring team found that 18 of the 38 SAPs reviewed (47%) were complete and contained clear examples of all of the components above. <u>Dental compliance and desensitization plans</u> Compliance and desensitization plans designed to teach individuals to tolerate routine dental evaluations were developed by the behavioral health services department. The behavioral health services department determined if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. The facility began to identify individuals that refused to allow routine dental evaluations. At the time of the onsite review, two individuals had dental desensitization plans to increase their compliance to dental exams. It is recommended that the facility compile a comprehensive list of all individuals who will not allow the dental department to conduct routine dental exams. This list should be presented to the behavioral services department to conduct their assessment to determine the type of plan necessary to address each refusal. Finally, the facility should utilize a system (e.g., spreadsheet) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams. Outcome data (including the use of medications) from dental compliance and desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail during future onsite visits. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in K9, the training of replacement behaviors that require the acquisition of a new skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. <u>Communication and language skill acquisition</u> The monitoring team was encouraged by the continued focus on communication SAPs. The facility's self-assessment indicated that 93% of individuals with severe communication deficits had communication SAPs. Also, see section R. <u>Engagement in Activities</u> As a measure of the quality of individuals' lives at SASSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement.	

#	Provision	Assessment of Status	Compliance
		Engagement of individuals at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each home and day program is listed in the table below. The monitoring team consistently observed staff attempting to engage individuals in activities at SASSLC. Additionally, the activities appeared to be more consistently based on individual interests than found in the last review. The average engagement level across the facility was 55%, a slight decrease over the last review (i.e., 63%). Since the last review, the facility modified their engagement tool. The new tool focused on the individual being actively engaged, rather than measuring that a DSP was interacting with the individual. Additionally, in order for an individual being scored as engaged, they must be actively engaged for at least two minutes of the three-minute observation. The monitoring team believes that these changes will result in a more meaningful measure of individual engagement at SASSLC. The engagement data collected by the facility for the month of March 2014 was 87%. As discussed in the last review, one likely explanation for the differences between the facility's data and the monitoring team's could be due to differences in how engagement data were collected. As described above, the monitoring team used a momentary time sample. That is, data were recorded as each individual engaged or not engaged based on what was seen at that moment of observation. On the other hand, the facility did a three-minute interval time sample. That is, the facility's observers watched a particular individual for three minutes and recorded engagement if that individual was engaged for at least two of the three-minute observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. The facility continued to utilize monthly active treatment meetings with active treatment coordinators, active treatment specialists, and DSP supervisors. In the active treatment meeting observed by the monitoring team, engagement data for each treatment site were presented, and suggestions for improving engagement were discussed. Finally, since the last review, the facility established individualized engagement goal levels for each treatment site at SASSLC. March 2014 data revealed that 75% of the homes, and 38% of day treatment sites achieved targeted goal engagement levels.	

#	Provision	Assessment of Status	Compliance
		The monitoring team believes that the facility is making progress in ensuring that the individuals at SASSLC are consistently engaged in meaningful and practical activities. Engagement Observations: Location / Engaged / Staff-to-individual ratio Home 668 — 1/7 — 1:7 Home 670 — 2/7 — 1:7 Home 670 — 4/6 — 1:6 Home 674 — 3/6 — 2:6 Home 674 — 4/4 — 2:4 Home 674 — 2/7 — 2:7 Home 672 — 3/5 — 2:5 Home 766 — 1/1 — 1:1 Home 673 — 1/4 — 1:4 Home 667 — 3/6 — 2:6 A 36 — 3/8 — 1:6 A 12 — 2/6 — 2:6 A 16 — 5/12 — 2:12 Vocational Workshop — 5/12 — 2:12 A 16 — 9 /10 — 2:10 A 36 — 7/8 — 3:8 C 13 — 2/6 — 1:6 Vocational Workshop — 3/6 — 2:6 Vocational Workshop — 4/10 — 3:10 Home 671 — 2/6 — 1:6 Home 671 — 2/3 — 1:3 Home 665 — 2/2 — 0:2 Home 665 — 3/3 — 1:3 Educational Services Eight students attended public school this past six months. Five of them will graduate in early June 2014. Their success in public school was due in part to the good relationship between the facility and the San Antonio ISD. Of the three remaining students, two were on the referral list, meaning that by next school year, it was possible for there to be one student from SASSLC. The facility QIDPs for these students, Eric Saenz and Carlos Rodriguez, continued to meet with SAISD special education department staff each month to review the status and	

#	Provision	Assessment of Status	Compliance
		planning for each student. Moreover, the QIDPs attended every ARD/IDP meeting. The facility staff worked with the ISD to plan for vocational and educational activities. Patrick Haas and Joseph Kenny, SASSLC vocational staff, were involved with these students. The ISPs, however, didn't contain much information about public school activities, or include action plans to support the IEP. For the next round of ISPs, the QIDPs should be sure to include this. ISPA meetings were held after report cards and progress notes were issued. The QIDPs said that these reports did not provide much useful information, especially when many of the students' objectives were marked as work in progress. Even so, it was good to see documentation from the QIDP that the report cards were reviewed and entered into the individual's record. Other than including more of the IEP into the ISP, the monitoring team does not have any other recommendations for the facility regarding their involvement and support of the individuals at the facility who attend public school.	
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.	SASSLC conducted annual assessments of preference, strengths, skills, and needs. This item was rated to be in noncompliance, however, because only 52% of SAPs reviewed were clearly based on assessments, and there was no documentation that these assessments were available to team members at least 10 days prior to each individual's team meeting. To assess compliance with this item, the monitoring team reviewed Individual Support Plans (ISPs), Functional Skill Assessments (FSAs), Preference and Strengths Inventories (PSIs), and Vocational Assessments (or sensory skills or retirement skills assessments) for five individuals. Individual #173 did not have a PSI. The self-assessment indicated that 63% of individuals at the facility have PSIs completed. All individuals should have assessments of preferences and strengths. In order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. Available data indicated that, over the last six months, 31% of FSAs were completed within 10 days of ISP. There were no data demonstrating that PSIs and vocational assessments were completed at least 10 days prior to the ISP. As discussed in the last review, the FSA appeared to be an adequate tool for assessing skills. No assessment tool, however, is going to consistently capture all the important	Noncompliance

#	Provision	Assessment of Status	Compliance
		underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be worn, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there are considerable data that demonstrate that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs in any of the FSAs reviewed. There was, however, some evidence of the development of individualized assessments (e.g., public transportation assessment, retirement assessment, sensory assessment, etc.) at SASSLC that can be used to develop SAPs (see examples below). Overall, the five individuals reviewed had a total of 27 SAPs, and 14 of those (52%) contained clear documentation that assessments were used to develop them. This was similar to the last review when 54% of the SAPs reviewed included documentation that assessments were used to develop them. Clear examples of assessments that were used to develop SAPs included: • Individual #173's vocational SAP to stay on task was based on the results of his vocational assessment, which indicated that he needed to improve his attention to task. Individual #173's ISP also reflected a discussion that staying on task could increase the amount of money he earns, which is desired by Individual #173. • Individual #116's PSI documented that her most consistent preference was staff interaction. Additionally, her sensory assessment indicated that she had the ability to reach for staff to attain their attention. Therefore, a SAP to teach her to reach for staffs' hand was developed to increase her ability to consistently initiate staff interactions. • Individual #280's communication and retirement assessments documented that he lacked communication skills and, therefore, they recommended a SAP to operate a communication device to request snacks. Examples of SAPs where it was not clear how or if assessments impacted their development included:	

#	Provision	Assessment of Status	Compliance
		• Individual #116 had a SAP to open her mouth so her teeth can be brushed. Her FSA and ISP, however, reported that she keeps her mouth open to have her teeth brushed. • Individual #280 had a SAP to press a button in the nurses' station to get the nurse's attention. There was nothing, however, in his ISP, FSA, or PSI suggesting that this SAP was based on an assessment of need or preference for Individual #280. • Individual #160 had a SAP to increase her attention to work tasks. Her vocational assessment, however, indicated that she worked in the community and had received positive work evaluations Over the next six months, SASSLC needs to ensure that all assessments of individuals' preferences, strengths, skills, and needs are completed at least 10 days prior to the ISP. Additionally, the facility should ensure that there is documentation of how assessments were used to select individual skill acquisition plans.	
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	SASSLC needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity, before this item is rated as being in substantial compliance. QIDPs at SASSLC summarized SAP data monthly. Monthly reviews of SAP data for five individuals were requested to evaluate compliance with this provision item. Monthly reviews for only two individuals (i.e., Individual #280 and Individual #128) were received. Individual #116 had monthly reviews for some SAPs, but not for all. This is similar to the last review when only two of five monthly reviews were available. All SAP data should be reviewed monthly. All SAPs reviewed (100%) contained graphed SAP data. SASSLC's self-assessment indicated that approximately 96% of all SAPs were graphed. The available monthly data summaries did not, however, consistently include graphed data summaries. There were a few clear examples of data-based decisions concerning the continuation,	Noncompliance

#	Provision	Assessment of Status	Compliance
		discontinuation, or modification of skill acquisition plans, however, there were several examples of SAPs that appeared to achieve objective levels, but continued to be implemented (e.g., Individual #173 shaving SAP, Individual #116 reaching for a staff's hand SAP, etc.). One encouraging sign, however, was the beginning of the use of program change forms to document changes in SAPs (e.g., Individual #173's counting SAP was discontinued due to lack of progress). The new document change forms appear to be an excellent format for documenting data based changes in SAPs. It is recommended that all individuals have monthly graphed summaries of SAP performance. Additionally, these graphed data summaries of individual SAP progress should be used to make data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans. As in past reviews, the monitoring team observed the implementation of SAPs to evaluate if they were implemented as written. For the SAP observed (Individual #178's handwashing SAP), the prompt did not appear to be clearly stated in the SAP, and therefore, the DSP did not know what level of prompt to provide. Additionally, the monitoring team encountered several examples of SAP data being incorrectly recorded (e.g., Individual #280's SAP to put on his shirt had data sheets that indicated that he was independent and required verbal prompts in the same trial). The only way to ensure that SAPs are implemented and documented as written is to conduct regular integrity checks. This represented another area of improvement. Since the last review SASSLC expanded treatment integrity measures to all treatment sites. The monitoring team observed the implementation of SAP integrity. The treatment integrity tool used by the facility included several questions concerning the SAP, such as "why is this person working on this objective." It also included a direct observation of the implementation of the SAP, and a rating of if it was implemented as written. The scoring of the SAP integrity did not, however, include the direct observation in the integrity score. The monitoring team believes that it is important to include the observation of the SAP implementation and scoring in the integrity score. At this point, it is recommended that the measure of treatment integrity be extended to direct observation of the SAP. Additionally, it is recommended that acceptable treatment integrity levels are established, and that the facility document that they have achieved those integrity levels. In order to attain substantial compliance, the SASSLC needs to demonstrate that data based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity.	

#	Provision	Assessment of Status	Compliance
	(b) Include to the degree practicable training opportunities in community settings.	SASSLC made progress in this area. In order to achieve substantial compliance with this provision item, however, the facility needs to demonstrate that established recreational and training goals are consistently achieved. SASSLC developed a community recreational and training database, and established individualized recreational and training goals in each home. March 2014 data indicated that three of eight homes (38%) achieved their community recreation and community training goals. This represents an improvement from the last review, when there were no community recreation goals established, and only 12% of the community training goals were achieved. At the time of the review, two individuals at SASSLC were competitively employed in the community. This represents a slight decrease from the last review when three individuals were competitively employed in the community.	Noncompliance

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: ○ Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments • State office guidance documents regarding special review process (November 2013) and potentially disrupted community transitions (December 2013) ○ SASSLC facility-specific policies regarding most integrated setting practices • 300-21A, Facility Most Integrated Setting Practices, 12/1/11 ○ SASSLC organizational chart, undated but likely February 2014 ○ SASSLC policy lists, undated, 2/15/14 ○ List of typical meetings that occurred at SASSLC, undated but likely February 2014 ○ SASSLC Self-Assessment, 4/17/14 ○ SASSLC Action Plans, 4/17/14 ○ SASSLC Provision Action Information, 3/23/14 ○ SASSLC Most Integrated Setting Practices Settlement Agreement Presentation Book ○ Presentation materials from opening remarks made to the monitoring team, 4/28/14 ○ Community Placement Report, last six+ months, 9/1/13 through 4/27/14 ○ List of individuals who were placed since last onsite review (10 individuals) ○ List of individuals who were referred for placement since the last review (13 individuals, including 2 referred during the week of the review) ○ List of individuals who were referred and placed since the last review (0 individual) ○ List of total active referrals (29 individuals, including 2 referred during the week of the review) ○ List of individuals who requested placement, but weren't referred (0 individuals) • Documentation of activities taken for those who did not have an LAR (n.a.) • Those who requested placement, but not referred due to LAR preference (n.a.) ○ List of individuals who were not referred solely due to LAR preference (0 individuals) ○ List of rescinded referrals (2 individuals) • ISPA notes regarding each rescinding (2 of the 2 [both were the ISPs]) • Special Review ISPA Team minutes for each rescinding (none) ○ List of individuals returned to facility after community placement (1 individual) • Related ISPA documentation (none) • Root cause analysis (none) ○ List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement, and a brief narrative for each case • 4 of 23 individuals who moved since 4/22/13

	○ Completed Potentially Disrupted Community Transition forms (2) ○ List of individuals who died after moving from the facility to the community since 7/1/09 (0, 0 since the last review) ○ List of individuals discharged from SSLC under alternate discharge procedures and related documentation (0 individuals) ○ APC reports • APC Department meeting minutes (none) • APC weekly reports, version for state office only, 2/7/14-2/28/14 (4) • Handout from morning medical meeting, 4/30/14 ○ SASSLC T1b ISP auditing tool, blank form, one completed form ○ Transition specialists' monthly notes (and email correspondence) regarding the transition activities for six individuals still on the referral list for more than 180 days and for three of the individuals whose transitions took more than 180 days ○ Post move monitor notes regarding Individual #318, Individual #140, and Individual #148's post move difficulties ○ Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair • Community tours • Work with local LA • Work with local providers • Facility-wide staff trainings/activities • For individuals • For families ○ Description of how the facility assessed an individual for placement ○ List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred), undated ○ List of individuals who had a CLDP completed since last review (10) ○ APC CLDP assessment tracking log ○ SASSLC CLDP self-auditing tools for T1c2, T1c3, T1d, and T1e, 1-2 completed examples of each ○ QA related activities and documents • APC presentation packet to QAQI Council, 4/29/14 • QA reports for last six months ○ State obstacles report and SSLC addendum, March 2014 ○ PMM tracking sheet, 5/2/14 ○ Transition T4 materials for: • (none) ○ ISPs for: • Individual #325, Individual #349, Individual #194, Individual #279, Individual #118 ○ Draft ISP used during the ISP meeting: • Individual #337, Individual #90 ○ CLDPs for:

	• Individual #318, Individual #72, Individual #113, Individual #140, Individual #271, Individual #148, Individual #266, Individual #156, Individual #99, Individual #350 o Draft CLDP for: • (none) o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #97: 90 • Individual #83: 45, 90 • Individual #155: 45, 90 • Individual #350: 7, 45, 90 • Individual #99: P, 7, 45, 90 • Individual #156: 7, 45, 90 • Individual #266: P, 7, 45, 90 • Individual #148: 7, 45 (returned to facility) • Individual #271: 7, 45, 90 • Individual #140: P, 7, 45, 90 (monitoring team attended the 90-day) • Individual #113: P, 7 • Individual #72: P, 7 <u>Interviews and Meetings Held</u>: o Tania Fak, Admissions and Placement Coordinator o Darlene Morales, Post Move Monitor o Lisa Nightingale, Transition Specialist o Group home staff at Just Like Home Centers agency apartment <u>Observations Conducted</u>: o CLDP meeting for: • (none) o ISP and pre-ISP meetings for: • Individual #337, Individual #90 o Living options discussion meeting for: • Individual #183 o Community apartment visit for post move monitoring for: • Individual #140
	Facility Self-Assessment The self-assessment given to the monitoring team was almost the identical self-assessment used in the previous review. The activities of the self-assessment were the same. This time, however, the APC included a lot of information, data, graphs, and explanatory narrative in the results sections. This was good

	to see. For example, data were included in T1b1, T1b2 (for tours only), T1c1, T1d, and T1e. The APC's data for T1d lined up with the monitoring team's findings. The data for T1e did not. The APC's scorings were higher than the monitoring team's due, most likely, to her scoring being based on the presence of pre and post move supports in each category rather than a review of the quality of those supports (and whether any supports were missing). This monitoring report contains metrics within each provision. Each metric is preceded by a letter. The APC should use these to develop her next version of the self-assessment. For this review, the APC self-rated the following 5 provisions to be in substantial compliance: T1c2, T1c3, T1h, T2a, and T2b. The monitoring team agreed with these self-ratings
	Summary of Monitor's Assessment Progress continued. Given that the APC had completed her first six months in this position, the department was only recently fully staffed, and many individuals were placed and referred, it was not surprising that only limited progress was seen in the many procedural requirements of section T. The monitoring team acknowledges the hard work of the APC and her staff. It appears likely that progress towards substantial compliance will be made over the next six months. Ten individuals were placed in the community since the last onsite review. 29 individuals were on the active referral list. Of the 23 individuals who moved in the past 12 months, 2 had one or more untoward events that occurred within the past six months (15%). Systemic issues were identified that competed with referrals and transitions. These were noted to be lack of community provider expertise in supporting individuals with complex behavioral and psychiatric needs, availability of community psychiatrists, absence of adequate day and employment programs, and provider challenges in creating accessible housing. The ISP-related components of section T were not being addressed to criterion, including individualizing and implementing actions to address obstacles to referral. The APC and the new QIDP coordinator were planning to collaborate on this over the next few months. CLDPs were much improved compared with previous reviews. Lists of pre- and post-move supports contained a wider range of supports than ever before. Discharge assessments, however, were not designed around the individual's upcoming move and new residential, day, and/or employment settings. Post move monitoring continued to be implemented as required and maintained substantial compliance. 29 post move monitorings for 13 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed-up when action was needed. Post move monitoring was observed by the monitoring team. The individual was reported to have

	exhibited problem behaviors at the apartment complex and the provider was unable to successfully deal with these. State office was notified following the post move monitoring visit.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		

T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	<u>Placement Department Staff</u>
		SASSLC continued to make good progress across section T. The admissions and placement staff remained the same (one post move monitor and two transition specialists) and continued to operate under the leadership of Tania Fak, the admission and placement coordinator (APC). The APC and her staff were quite busy with numerous referrals and transition activities.
		
		<u>Transition-Related Numbers</u>
		Transitions:
		• The number of individuals placed was at an annual rate of about 9%. 10 individuals had been placed in the community since the last onsite review. This compared with 11, 12, 1, 2, 5, 1, 3, and 5 individuals who had been placed at the time of the previous monitoring reviews.
		
		Referrals:
		• 13 individuals were referred for placement since the last onsite review (including 2 referred during the onsite week). This compared with 24, 18, 9, and 8 individuals who were newly referred at the time of the previous reviews.
		  o 0 of the 13 individuals were referred and placed since the last review.
		• 29 individuals were on the active referral list (including 2 referred during the onsite week). This compared with 27, 15, 15, 10, 9, 4, and 3 individuals at the time of the previous reviews.
		  o 16 of the 29 individuals were referred for more than 180 days. This compared to 7, 5, and 6 at the time of previous reviews.
		  o 3 of these 16 individuals were referred for more than one year. This compared to 1 and 0 at the time of previous reviews.
		
		Although the facility maintained a higher number of referrals than ever before, the pace of transitions did not keep up, resulting in a large increase of individuals who's referrals had surpassed 180 days and even one year.
		
		<u>Determinations of professionals</u>
		Professional members of the IDT are required to state their opinion regarding the most integrated setting for each individual in their annual assessments, during the ISP
			Noncompliance

		meeting, and in the written ISP document. Compliance is addressed in T1b3. <u>Placement and referral not opposed</u> a. In reviewing the CLDPs (10) and ISPs (1) for 11 individuals who were on the referral list or who had been placed, 11 (100%) individuals and/or LARs did not oppose transition to the community. One individual did not want to move, however, he had an LAR who made the decision for him to move. The transition and new home turned out very well for him. He liked his new home and had fewer behavior problems than when at SASSLC. <u>Responding to individual requests and rescinded referrals</u> There were 2 rescinded referrals since the last review. This compared to 0, 5, 2, 4, 2 and 3 at the time of previous reviews. Documentation (ISPA notes, ISPs, or SRT) was provided for 2 of the 2 individuals regarding the reasons for the rescinding. b. Of these 2, the reasons for the rescinding appeared to be reasonable for 0 (0%). • One was rescinded because the individual did not seem comfortable going on group home tours. • The reason for the other was unclear in the ISP. It appeared to be family preference, however, there were no action plans in the ISP to address any obstacles to referral, including family preference. An adequate review to determine if changes in the referral and transition planning processes at the facility was conducted for 0 (0%) of the rescinded referrals. Of these reviews, actions were recommended in n.a. (n.a.%) cases. Of these, actions were implemented for n.a. (n.a.%). These discussions should be documented in a clearly identified portion of an existing document, such as within weekly APD meeting minutes. The rescinding of a referral should not be considered a failure and should not deter IDTs from referring individuals. A review for quality improvement purposes, however, should be conducted for all. c. 0 individuals were described as having requested placement, but were not referred. This compared with 0, 5, 7, 5, and 7 individuals at the time of the previous reviews. Because no individuals were identified, the following metrics were not applicable. Of the n.a. individuals who requested placement, but were not referred, n.a. individuals had an LAR who made this decision. Of the remaining n.a. individual, an appropriate review, appeal, and or lack of consensus review was conducted for n.a. (n.a.%). • The APC, however, reported that her department was working on determining an accurate number. In other words, there likely were individuals who had requested referral but were not referred. However, she had no way of accessing that information.	

		The list of individuals not being referred solely due to LAR preference contained 0 names. This compared to 0 individuals at the time of the previous reviews. • This was likely an incorrect count. Further, the self-assessment indicated 15 individuals based upon ISPs from September 2013 to December 2013. <u>Systemic issues</u> d. There were systemic issues delaying referrals (at the state and/or facility level). Ninety percent of the individuals were not referred. • The APC pointed, in her annual report, to individual and LAR preference, however, it appeared to the monitoring team that, in addition, a lack of competent providers to address behavioral/psychiatric needs and/or complicated medical needs were barriers to individuals and LARs choosing referral to the community. This was based upon monitoring team interviews and monitoring team review of ISPs and other ISP-related documents. • At the two ISPs observed by the monitoring team, the LA representative, rather than speaking about potential advantages of community life that the team could consider, recommended that each individual not be referred. The LA representative, as a professional, should certainly give his or her determination about community referral. Given the LA representative's knowledge and expertise about community living, the monitoring team, however, would have expected a more detailed presentation of how the determination was arrived at. e. There were existing and/or potential systemic issues delaying transitions (at the state and/or facility level). • Given the current set of individuals who were referred, the primary issue appeared to be a lack of community providers with competence and expertise in supporting individuals with complicated behavioral and psychiatric problems. Although the facility was trying to work locally with the San Antonio providers, there was a limit to what they could accomplish without action from the state. • The APC reported that a lack appropriate day and employment providers who could meet the needs and preferences of individuals delayed transitions. Employment was important for many individuals, but there was a lack of these types of opportunities in the community provider network. • The monitoring team surmised that there was also a lack of community provider expertise in supporting individuals with complicated medical needs, but because no individuals on the referral list had these needs, it was not an issue for the current set of referrals.	

		• It also may be that there were not enough staff in the APD to adequately deal with a referral list of almost 30 individuals. f. Funding availability was not cited as a barrier to individuals moving to the community. g. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list. • This was done by the APC during presentations at morning clinical meetings once each week. In addition, she sent a weekly email to senior managers and presented once each month at QAQI Council. <u>Pace of transitions</u> h. Transitions were not occurring at a reasonable pace. To make this determination, the monitoring team reviewed CLDPs, ISPs, ISPAs, 180 day meeting notes, any APD meeting minutes or reports, the APC's weekly enrollment report sent to state office, and various emails and meeting minutes. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office. • Of the 10 individuals placed since the time of the last onsite review, 4 (40%) were placed within 180 days of their referral (i.e., 6 were not). o 2 of the 6 were placed after more than one year of being referred. • At the time of the review, 29 individuals had been referred for community transition. 16 of these 29 individuals had exceeded the 180-day timeframe. o Of the 16, 3 individuals had exceeded one year. A sample of 3 of the 6 individuals who were placed after more than 180 days, and 6 of the 16 individuals on the referral list for more than 180 days was chosen for metrics .i., j., and k. That is a total of 9 individuals. i. Reasonable activity and actions had occurred related to the transition and placement for 5 of the 9 (56%) individuals. IDTs did not meet each month for the individuals who were past 180 days on the referral list. Although this was not a Settlement Agreement requirement, it was part of the state's policy and would improve the facility's documentation of IDT activity regarding these transitions. • Of the sample of 6 of the 16 individuals referred for more than 180 days, reasonable activity was taken for 2: o It appeared that a lot of activity occurred for Individual #22 and	

		Individual #118, though these cases appeared to be examples where the APC and her staff might have called upon state office for assistance. For Individual #22, the provider's inability to locate a bathroom lift delayed his move for months. For Individual #118, the provider's inability to secure fire marshal approval for four individuals delayed his move for months; eventually, his LAR chose another provider. o For the other 4 individuals, there had been no activity for many months following their referrals. In the past four or so months, however, a lot of activity had occurred. • Of the sample of 3 of the 6 individuals who were placed and who had been on the referral list for more than 180 days, reasonable activity and actions were taken for 3: o The monitoring team could determine that, for 2 of the 3 individuals, the reasons for the delays were indecision in choosing a provider and a hospitalization (Individual #140), and absence of a DID/DMR form (Individual #72). The monitoring team, however, could not determine why these obstacles to transition delayed the transition. For both of these individuals, their CLDP contained a single sentence about the delay. Additional information submitted by the APC (e.g., transition specialist logs, emails) allowed the monitoring team to have a better understanding of activities taken. • It seemed that transition related activity had increased in the past four or so months due, largely, to the APD being fully staffed, oriented, and more and more experienced with transition processes, obstacles, and the provider community. j. There were no gaps of time (e.g., multiple months) during which little or no activity occurred for 5 of the 9 (56%) individuals. k. Adequate justification was provided for the lengthier transition process for 4 of the 9 (44%) individuals.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall	<u>State policy</u> a. The state policy for most integrated setting practices was recently issued. It did not address all of the items in section T of the Settlement Agreement. Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team	Noncompliance

	require that:	recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spelled out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken <u>prior</u> to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. • There was no mention of need for the IDT to use CLDP to ensure supports are in place. • The policy listed two reviews of CLDPs to be undertaken, one at the facility and one at state office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. o The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the Monitors and the content of the monitoring reports. <u>Facility policy</u> b. There were not facility policies that supported the state policy for most integrated setting practices. • There was one facility policy related to most integrated setting practices, but	

		it was merely the state policy. The facility, however, should have policies and procedures that operationalize/define implementation of the parts of the state policy that are not specific. Examples include (but are not limited to) the way in which community tours are managed, how educational activities are presented to individuals, how the admissions and placement department staff ensure that all supports and services are included in CLDPs, how the PMM conducts post move monitoring, and which staff are to review the CLDP prior to its submission to the facility director. Training of facility staff on policies is addressed in T1b2 below. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	
	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.	This section relates to the activities of the IDT, QIDP, and the ISP process. The APC spoke about a newly formed committee with the QIDP coordinator to address these topics. This group should be able to adequately address the metrics in this provision (T1b1) as well as the other ISP-related provisions of section T, which include T1b2 item#1, and all of T1b3. The monitoring team recommends that the APC and QIDP coordinator begin to collect data on these same metrics as does the monitoring team. <u>Protections, services, and supports</u> a. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted in section F, substantial compliance was not found for F1d, F2a1, and F2a3. There was some indication that teams, with direction and prompting from the APC and her staff, were developing SAPs to assist the individual in preparing for moving to the community once referred. For example, at the living options discussion and referral meeting for Individual #183, the APC prompted the team to think about what skills would help him to be successful living in his specialized foster care arrangement with his mother. The team, with the mother's input, identified independent laundry and independent shaving. SAPs were scheduled to be developed. The written ISP for Individual #118 noted that he did not correctly discriminate men's and women's bathrooms when in the community and, given that this was important for his upcoming move, created a SAP. The written ISP for Individual #279, however, did not include any SAPs preparing him for his upcoming move. For the sample of 5 individuals who's CLDPs were reviewed (see below), 0 individuals had SAPs developed and implemented to help prepare the individual for his or her	Noncompliance

		transition during the period between referral and placement. Obstacles to movement The monitoring team reviews a sample of ISPs for monitoring of this provision. The facility submitted 8 ISPs, however, 4 of these occurred prior to the last onsite review (or within a week or two after it) and, therefore, were not relevant to this onsite review. Thus, the monitoring team used the other 4 and added 1 other from another set of documents for a total of 5. Regarding referral at the individual level: b. Of the 5 ISPs reviewed, 3 should have had obstacles to referral defined (the other 2 individuals were referred for transition to the community). Of these 3 ISPs, 0 (0%) included an adequate list of obstacles to referral. Obstacles to referral were not explicitly stated. As a comparison, the APC's self-assessment reported that only 64% of the ISPs in her self-assessment sample had obstacles stated in the ISP. c. Of the 2 annual ISP meetings observed, an adequate list of obstacles to referral was identified for 2 of 2 (100%). • Both teams engaged in discussion regarding obstacles to referral and all team members participated in the discussion. A plan to address obstacles at the individual level: d. Of the 3 ISPs, 0 (0%) included an action plan to address/overcome obstacles identified. Therefore, the following metric could not be determined: Of these n.a., n.a. (n.a.%) were adequate (i.e., were individualized, measurable, and comprehensively addressed the obstacles). • More specifically, 2 of the 3 ISPs did not include plans that addressed the specific obstacles the team had identified, but rather included generic efforts to provide more information to the individual about community options. For instance, for two of the individuals, there were action plans to go on community tours, however, for both of these individuals, tours were likely not relevant to the obstacle to referral, which appeared to be more related to medical needs and LAR preference. In other words, a tour might be a relevant activity for the individual, but it was insufficient to address the obstacle to his or her referral. e. Of the 2 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 1 (50%). Of these, 0 (0%) were adequate. • Overall, there was an absence of action plans that directly lined up with the actual obstacles or the reasons behind the obstacles (i.e., the reasons for LAR preference, the reasons why medical needs were an obstacle). • For Individual #337, the team agreed that her lack of knowledge about	

community living options was an obstacle to referral for community placement. The QIDP facilitator reported that she did not make progress on her outcome to visit homes in the community last year because she refused to get off the van when visiting group homes. The IDT agreed to continue her outcome from the previous year to participate in group home visits. They did not, however, discuss why she might have refused to participate in group home visits, how they might modify supports, or whether visits to group homes were important for her (e.g., was it meaningful, did she understand the purpose).

- Individual #90 had the same outcome as Individual 337, that is, to visit community providers to address her lack of knowledge about community living options. The facilitator stated that the IDT had no documentation of implementation for the past year. Her team also agreed to continue the outcome without addressing barriers to implementation. It was noted that a second outcome to participate in community activities was not fully implemented due to lack of transportation for outings. The IDT, again, continued the outcome without addressing barriers to transportation. Probably more relevant were comments by her nurse case manager and PCP who both cited her health and need for 24 hour nursing services as obstacles to community placement.

Regarding transition at the individual level:

f. Of the 5 CLDPs (and related ISPAs) reviewed, 3 should have had obstacles <u>to transition</u> defined. Of these 3 CLDPs and/or ISPAs related to transition, 0 (0%) included an adequate list of obstacles to transition.

g. Obstacles to transition were defined for 0 individuals. Of these n.a. individuals, n.a. (n.a.%) had action plans to address the obstacle <u>to transition</u>.

- An obstacle to transition for an individual on the referral list (Individual #118) was that the provider needed approval from the municipality fire marshal for a fourth resident. This delay had gone on for more than year. The IDT decided to wait because this was a good placement for him, but there was no indication of any action taken by the facility to move this along. Unfortunately, the LAR recently decided to pursue a different provider.

<u>Preferences of individuals and LARs</u>

Preferences of individuals are determined and described:

h. Of the 5 ISPs, 4 (80%) included an adequate description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).

- 2 of the 5 were unable to clearly provide their preferences. For 1 of the 2, the IDT, however, described ways they tried to determine the individual's preferences, such as by demeanor and responsiveness to tours.

		i. Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 0 (0%), and this preference appeared to have been determined in an adequate manner for n.a. (n.a.%). • Neither team discussed the individual's living preferences other than to say that they could not determine the individual's living preference. Preferences of LARs are determined and described: j. Of the 5 ISPs, 4 (80%) included an adequate description of the LAR's preference and how that preference was determined by the IDT. k. Of the 2 annual ISP meetings observed, the LAR's preference for living setting was adequately described in 2 (2%), and this preference appeared to have been determined in an adequate manner for 2 (100%). . Both LARs were present at the annual IDT meeting and they were given the opportunity to state their preference.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	1. Individualized plan: a. In reviewing 5 recently completed ISPs, 2 individuals had been referred for placement and were engaged in the CLDP process. For the remaining 3, 0 (0%) had a plan that addressed education about community options. Therefore, the following metric could not be assessed: Of these, n.a. (n.a.%) were adequate. Regarding the plans for education in this set of 3 ISPs: • 0 of the 3 (0%) had a list of activities that was individualized and specified what will be done over the upcoming year. To meet criteria with this metric, the plan should go beyond a generic provision of information; it should reflect the specific concerns that individuals and families/LARs have raised about the community, as well as reflective of the individual's needs. o The most challenging area with regard to education of individuals and LARs/families is individualizing this process. Action plans should target specific types of providers for community tours, identify research that the team would do to answer the individual/LAR's specific questions, include visits to peers with similar needs that had moved to the community, etc. It is essential that teams individualize action plans to address the reasons for the individual, family member, or LAR's reluctance/preference. For example, if an LAR has questions or concerns 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. When teams have questions about availability of supports in community settings,	Noncompliance

these should be researched.
    - In the 2 ISP meetings observed during the onsite review, an individualized plan was not discussed or created.
- 0 of the 3 (0%) were in measurable terms and provided for the team's follow-up to determine the individual's reaction to the activities offered.
- 0 of the 3 (0%) included the LAR, as appropriate, based upon the content of the ISP. This was also evident in the two ISPs observed.
- 0 of the 3 (0%) adequately described how/if the previous year's plan was completed.

It may be helpful to:

1. Add some prompts or headers to the ISP shell to help the IDT address each of the above four bullets.
2. Have the transition specialist who attends the ISP meeting ensure that the IDT always adequately addresses these four bulleted items.
3. Train and review these, with data, during the APC-QIDP coordinator F & T workgroup meetings.

<u>2. Provider fair</u>:

b. The facility did hold a provider fair within the past 12 months (on Saturday 11/16/13). Data were not collected on a variety of variables (e.g., attendance, participation, satisfaction, suggestions), but instead only on a single variable: individual attendance. Data from previous fairs were not used to make changes to new fairs. The APC reported that two families attended for the first time, but many individuals did not attend because of competing community and other recreational activities scheduled on that Saturday (and on most Saturdays).

<u>3. Local MRA/LA</u>:

c. The facility did appear to maintain good communication and a working relationship with the LA. The facility participated in quarterly meetings with the LA, and ensured relevant topics were on the agenda for the LA meetings.

<u>4. Tours of community providers</u>: 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).

d. The facility did not have an adequate system to track and manage tours of community providers (i.e., identified all individuals for whom a tour was appropriate, identified all individuals and whether or not each went on a tour).
    - To meet this aspect of T1b2, the facility needs to demonstrate that:
        - 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).
            - It appeared that tours were almost solely for individuals

		who were already referred. This was important in helping them make a decision about providers. Opportunities for tours were in many other individuals' ISPs, but had not occurred. o Places chosen to visit are based on individual's specific preferences, needs, etc. o Tours are for individuals or no more than four people. ▪ This was the case for all tours. o Individual's response to the tour is assessed. ▪ Staff completed a short report form. e. The facility did not have data for the following metric: Based on the facility's own report, of the n.a. individuals at the facility for whom a tour was appropriate, n.a. (n.a.%) went on a tour appropriate to their needs within the past year. f. Of the 4 individuals in the sample for whom their teams had determined a tour was appropriate, 1 (25%), Individual #118, went on a tour tailored to their needs within the past year. To meet the standard for this item of T1b2, at least 90% of the individuals for whom a tour was appropriate should have attended a tour. <u>5. Visit friends who live in community</u>: g. The facility did not have a process to identify individuals who would benefit by visiting friends who had moved to the community, and a process for making it happen. <u>6. Education activities at/by facility for individuals</u>: h. Since the last onsite review, other educational activities for individuals did occur (during self-advocacy meetings), did not occur during house meetings for individuals (there were no house meetings), did not occur during family association meetings, and did not occur during any other appropriate situations or locations. • A few months ago, an individual who recently moved to the community attended a self-advocacy meeting and described her positive experiences. <u>7. Education activities for direct support professionals (DSPs), clinicians, and managers</u>: i. More than 75% of DSPs were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). • 40 staff were reported to have attended a community tour from September 2013 to February 2014. j. More than 75% of clinicians were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour). k. More than 75% of managers and administrators were not documented to have participated in one or more activities (e.g., inservice, workshop, community tour).	

		8. Reluctant individuals/LARs learn about successes: l. Since the last onsite review, information about successful community placements was not shared with (a) individuals who were reluctant to consider community placement, and (b) LARs who are reluctant to consider community placement. • The facility did not have a process for this to occur.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The monitoring team requested a set of recent ISPs, attachments, and assessments. Five were selected for review by the monitoring team (see above under Documents Reviewed and description in T1a). These were from the entire SASSLC campus, for individuals with differing levels of needed support, and facilitated by five different QIDPs. The ISPs were from meetings held December 2013 to January 2014. 1. Professionals provided recommendation in assessments: a. Assessments were reviewed for 4 of the 5 ISPs (assessments were not submitted for 1). Of the 4 ISPs reviewed, all of the assessments for 0 individuals (0%) included an applicable statement or recommendation from all disciplines. • The ISPs sampled were from some individuals who were referred and not referred. • Assessments were not completed (or perhaps were completed, but were not submitted) for all disciplines. • Statements were most regularly made in the habilitation and nursing. Statements from medical, dental, and behavioral health were included in the written ISPs for, but the assessments were not submitted, so the monitoring team was unable to determine the content of those assessments or if the comments in the written ISP were from a written assessment or from the discussion that occurred during the ISP meeting itself. • The state office new standardized statement/requirement was not being used by all disciplines all the time, but should be. • Below are some data for these 4 ISPs: Discipline # assessments # with a statement # w/ state statement Medical 0 of 4 Nursing 4 of 4 4 of 4 4 of 4 Dental 0 of 4 Psychiatry 1 of 4 1 of 4 1 of 4 Beh. Health 0 of 4 Pharmacy 0 of 4 OT-PT 4 of 4 4 of 4 3 of 4 SLP 4 of 4 4 of 4 0 of 4 Nutrition 4 of 4 0 of 4 0 of 4 Vocational 2 of 4 1 of 2 0 of 1	Noncompliance

		Sensory 1 of 4 1 of 1 0 of 1 Social Work 0 of 4 2. Professional determinations presented/discussed at ISP meeting: b. In 4 of the 5 (80%) written ISPs reviewed, and during 2 of the 2 (100 %) annual ISP meetings observed, independent recommendations from each of the professionals on the team to the individual and LAR were included. 3. Thorough discussion of living options at ISP or other IDT meeting: c. In 0 of the 5 (0%) written ISPs reviewed, and during 0 of the 2 (0%) annual ISP meetings observed, a thorough discussion of living options occurred. • While the living option discussion was much improved, the teams still failed to adequately address all obstacles to the individual living in the most integrated setting. Furthermore, the IDTs did not develop individualized outcomes to ensure that the individuals had the opportunity to gain additional meaningful community exposure. • In Individual #118's ISP, two of the IDT members did not recommend referral. The ISP did not report on how this lack of consensus was resolved during the meeting. 4. IDT determination in written ISP: d. In 0 of the 5 (0%) written ISPs reviewed, a complete and adequate statement of the opinion and recommendation of the IDT's professional members as a whole was included. e. In 2 of the 5 (40%) written ISPs reviewed, a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was included.	
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:	The APC submitted 10 CLDPs completed since the last review. This was 100% of the CLDPs completed since the last review. The monitoring team reviewed 5 of the 10 (50%) CLDPs in depth. Timeliness of CLDP Initiation of CLDP a. 0 of the 5 (0%) CLDPs were initiated within 14 calendar days of referral. The monitoring team based this finding by reviewing documentation of CLDP-related activity occurring within 14 days of referral, including the actual 14-day meeting minutes or indication on the CLDP cover/first page. Based upon report from the APC, the CLDPs were initiated within 14 days, but there was no documentation regarding this. Ongoing development of CLDP b. 5 of the 5 (100%) CLDPs included documentation (e.g., ISPAs or other document) to	Noncompliance

		show that they were updated throughout the transition planning process. Paragraphs in section IV of the CLDP contained some information about the activities that occurred for the longer transitions, but it was extremely brief. The APC submitted other documents that showed the activities that occurred each month for each individual. <u>IDT member participation in placement process</u> c. 1 of the 5 (20%) CLDPs or other transition documentation included documentation to show that IDT members actively participated in the transition planning process (e.g., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). The CLDP for Individual #72 indicated more IDT involvement than the other CLDPs. Individual #266's CLDP called for an individualized transition plan, however, this did not appear to have been done. <u>Coordination of CLDP with LA</u> d. n.a. of the 5 (n.a.%) CLDPs or other transition documentation included documentation to show that the facility worked collaboratively with the LA. The monitoring team chose to not rate this metric because this collaboration did not appear to be more than the LA's attendance at the CLDP meeting, the provision of provider lists, and conducting the LA's own pre move site review (separate from the facility's pre move site review). On the other hand, the delays in transition seemed to be areas where the LA could have taken a stronger role (e.g., obtaining a DID/DMR, helping with the fire marshal).	
	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 CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the LA and community provider. <u>The CLDP specifies actions to be taken by facility</u> a. 0 of the 5 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed below, in the six closed bullets, occurred adequately and thoroughly. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of training required. Each of the CLDPs included a lot of good detail about the content of training (i.e., what was to be trained). i. who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), 1 of 5 (20%) (Individual #72), ii. the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a	Noncompliance

		plan in vivo, such as a PBSP or NCP), 0 of 5 (0%), and iii. a competency demonstration component, when appropriate, 5 of 5 (100%). • Collaboration with community clinicians (e.g., psychologist, behavior health specialist, psychiatrist, PCP, nurse, SLP). This was noted in 2 of the CLDPs (40%) for psychologist/behavior analyst to psychologist/behavior analyst (Individual #99, Individual #72). This likely should have also occurred for Individual #140. If collaboration with community clinicians was considered by the IDT and perhaps deemed not necessary, the CLDP should indicate this decision. • Assessment of settings by SSLC clinicians (e.g., OT/PT). This was noted in 0 of the 5 CLDPs (0%). (It was noted in some of the documentation for Individual #22, an individual on the referral list. That is, many members of his IDT visited the potential home, including OT and PT.) • Collaboration between provider day and residential staff. This was not evident in any of the CLDPs (0%). • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not evident in any of the CLDPs (0%). If not needed, this should be indicated in the CLDP. o The CLDP for Individual #113, however, indicated that two different SASSLC staff would maintain contact with him and visit him for a number of weeks after his move. • Collaboration between Post-Move Monitor and Local Authority staff. This may likely have been occurring, but was not noted in any of the CLDPs. The facility reported that the APC shared the PMM's reports with the LA. It may be helpful to: 1. Include these six items within section IV of the CLDP. 2. Add these six items to the APC's CLDP supports checklist. <u>Documentation of day of move activities</u> b. 5 of the 5 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and the responsible staff member. Documentation for 0 of the 5 (0%) indicated that the activities did indeed occur. <u>CLDP meeting prior to moving</u> A CLDP meeting occurred for 5 of the 5 individuals (100%). It was described in each of the CLDPs c. A CLDP meeting did not occur during the onsite review. The monitoring team suggests that the APC consider the following when preparing for CLDP meetings: • <u>Attendance by all relevant IDT members, community providers, and LA</u>	

		• Individual preparation occurred prior to the CLDP meeting, if appropriate to do so • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved • The post-move monitor actively participated to ensure that supports were adequately defined and required evidence specified.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The parties agreed the monitoring team would not monitor this provision because the facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. The following review was based on a sample of assessments from 5 of the CLDPs. <u>The assessments selected for completion are appropriate and none are left out</u> a. For 5 of the 5 CLDPs reviewed (100%), all necessary assessments were completed. <u>Assessments done within 45 days of move date</u> b. For 5 of the 5 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. <u>Assessments are available for use by the APC and IDT</u> c. For 5 of the 5 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting. <u>Assessments are of adequate quality</u> d. For 0 of the 5 CLDPs reviewed (0%), the assessments were of adequate quality based upon the following four closed bullets:	Noncompliance

		• A summary of relevant facts of the individual's stay at the facility. o The content of the assessments for most of the assessments for all 5 individuals contained relevant facts regarding the individual's stay at the facility. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o Most of the assessments for all 5 individuals were thorough enough to assist teams in developing a list of supports. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o The assessments for 0 of the 5 individuals specifically focused on the new home or day settings. • Assessments 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. o The assessments for 0 of the 5 individuals specifically focused upon how the necessary supports might need to be provided in these new settings. o This is particularly important for PBSP and psychiatric supports and should be corrected for future transition planning. It may be helpful to add metric d. to the APC's self-monitoring tool for T1d.	
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	The lists of pre-move and post-move supports were identified in the CLDPs. There was continued improvement in the lists of supports, however, more work was needed. The APC reported that she added prompts within the draft CLDP to help her to ensure that all important areas were included in the list of pre and post move supports. This seemed to have a positive effect. The APC and her staff should be encouraged by this finding. Overall, of the 5 CLDPs reviewed by the monitoring team, the most recent ones were the most extensive, including more than 40 pre and post move supports that covered most every area (e.g., Individual #72). <u>Pre- and post-move support lists are adequate</u> a. In 0 of the 5 CLDPs reviewed (0%), a comprehensive set of essential and nonessential supports was identified in measurable/observable terms. This finding was based on the following three numbered bullets. 1) The list is comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. ▪ This applied to 5 of the 5 individuals, and was demonstrated in	Noncompliance

	departure from the Facility.	2 of the 5 (40%). Merely saying to continue the PBSP was insufficient (Individual #99, Individual #266). Further, the CLDPs and PBSPs detailed many aspects about interaction style, communication, preferences, clothing, food, music, schedules, and so forth that were critical to each of these individual's success. ▪ For Individual #140, there was a large set of pre and post move supports (more than 40). Even so, the supports for psychology and psychiatry were inadequate. Further, consider that a week before the CLDP meeting he had "recent attempts to touch others at work (patted someone's butt)" and that his psychological assessment showed about 5 occurrences each month of inappropriate sexual behavior back to July 2013 (and a higher number each month during the months before July 2013). This should have been recognized by the IDT. His placement, at the time of this review, was in jeopardy (see T2a and T2b below). ▪ As appropriate, crisis intervention plans should be developed, and/or pre-move and post-move supports should define how the current methods for dealing with crises at the facility should be modified in a community setting. This was somewhat included in Individual #113's CLDP as a pre move support (it was for crisis intervention training, but was unclear if it was regarding how to specifically deal with Individual #113's possible crisis situations), but it should be a part of every CLDP for anyone with a history of behavioral and/or psychiatric issues. o All safety, medical, healthcare, therapeutic, risk, and supervision needs were addressed. ▪ This applied to all 5 individuals and was adequately done for 5 of the 5 (100%). SASSLC did a nice job with this. Examples included adaptive equipment, mealtime procedures, and pedestrian skills. o What was important to the individual was captured in the list of pre- and post-move supports. ▪ This applied to all 5 and was adequately addressed for 1 of 5 (20%). Most CLDPs rolled all of the preferred activities into a single support. o The list of supports thoroughly addressed the individual's need/desire for employment, and/or other meaningful day activities. ▪ Employment or day supports applied to 3 of the 5 individuals and was adequately addressed for 2 (67%). The IDT	

		acknowledged the importance of work for Individual #140, yet supported his move to a day hab program that would certainly last for many months. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of pre- and post-move supports. ▪ This was addressed in 3 of the CLDPs (60%). Positive reinforcement applied to all individuals and probably played a role in their success at the facility. It was mentioned in Individual #266's and Individual #140's CLDPs, but never became a support. o There were pre-/post-move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. ▪ This was addressed for all 5 (100%). o There were pre-/post-move supports for the provider's <u>implementation</u> of supports for 2 of the 5 (40%). This refers to the components of the PBSP, PNMP, dining plan, medical procedures, nursing care plans/IHCPs, therapy and dietary plans, and communication programming that community provider staff would be required to continue were not included. o All recommendations from assessments are included; or if not, there is a rationale provided. This occurred for 5 of the 5 CLDPs (100%). ▪ For the most part, recommendations were included. ▪ The APC wrote very detailed narratives of the discussion and deliberation that occurred for each of the disciplines during the CLDP meeting and how the discussion led to a set of what they called final recommendations. o This was a strength of the 5 CLDPs. 2) The wording of every pre-/post-move support is in measurable, and observable terms. o Many were in measurable terms, however, many continued to include wording, such as implement the PBSP, and ambulate/walk daily. 3) Every pre-/post-move support included a description of what the PMM should look for when doing post-move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o This was much improved and included more references to logs, checklists, and interviews. o The PMM should guide the IDT to consider <u>three</u> general categories of evidence: direct observation, staff interview, and documentation (e.g., checklists). For example, the safe eating post move support for	

		Individual #156 stated "observation by PMM, interview with staff, checklist." This appeared to be more improved in the most recent CLDPs. <u>Essential supports were in place on the day of the move</u> b. For the 5 of 5 (100%) CLDPs reviewed for individuals who were placed, a pre-move site review was conducted by the facility. c. Of these 5, 5 (100%) were done timely and completely. d. Of these 5, 5 (100%) indicated that all of the essential supports were in place prior to the individual's move, or if they were not, identified the issue and showed that action was taken to remedy the situation. e. For___ of __ (%) pre-move site visits observed by the monitoring team (if any), the pre-move site visit was conducted thoroughly (not applicable, none were observed by the monitoring team).	
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.	Policy/Procedure a. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. • The state recently developed and disseminated the beginnings of a section T/most integrated setting practices QA program to each of the facilities. It included three tools to assess the written completed CLDP document, written completed post move monitoring forms, and the written completed transition document for provision T4 type transitions. It included two sets of instructions (one page each). One was for the conducting of the three tools. The other was regarding the full set of transition-related data and review system. • The content of the three tools lined up better than ever before with the content of the monitoring team's metrics and reports. The state should again review the Monitors' reports for the next revision of these tools. • Tools regarding the important ISP-related components of section T were not addressed (e.g., T1a, T1b1, T1b2, T1b3). • The facility should have its own facility-specific policy/procedure for quality assurance to meet what is required by this provision T1f. Collection of data b. Data/information were not collected (i.e., a complete set of data were not being collected). The data that were being collected were relevant and valid. However, a complete set of data was not being collected. The data appeared to being collected reliably. • The monitoring team has, for some time now, recommended the following set of data to contribute to the APC's QA program and to set the occasion for summation, review, and analysis of data. These are simple data to collect	Noncompliance

		and graph. Some of it was already being done and good progress was seen. Those items are indicated with check marks. At this point, data were only presented for the past two-month period. 1. √ Number of individuals placed each month or monitoring period 2. √ Number of new referrals each month or six-month period 3. √ Number of individuals on the active referral list as of the last day of each month ▪ This was also done by home. 4. √ Number of individuals on the active referral list for more than 180 days, as of the last day of each month 5. √ Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers). 6. Number of individuals who have requested placement, but have not been referred, as of the last day of each month 7. Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month 8. Number of individuals not referred solely due to LAR preference as of the last day of each month 9. √ Number of individuals who had any untoward event happen after community placement each month (including return to the facility or death) and number that had a root cause type review ▪ Cumulative number of each type of untoward event for all placements 10. √ Number of rescinded referrals each month or each six-month period, and number that had a root cause type review 11. √ Number of alternative discharges (T4) 12. Number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles (from T1b1) 13. √ Number of individuals who went on a community provider tour each month and total number/percentage of individuals who went on a tour in the past 12 months (from T1b2) Summarization/analysis of data and actions taken c. Data were reviewed and summarized, but not analyzed. There was no narrative or explanation of the data. Actions were not taken as a result of analysis of the data. The data were included in the facility's QA program, but it was not a full set of relevant data.	

		Re-admissions: There was 1 re-admission. This compared with 0 re-admissions at the time of all of the previous reviews. d. For 0 of the 1 (0%) who returned to the facility after a failed community placement, an adequate review was conducted to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for n.a. (%). Deaths Following Community Placement: There were no deaths of individuals who had moved to the community. This compared with 0 deaths prior to this review. Because there were no deaths of individuals who had moved to the community, the following metric was not applicable to this review. e. ___ individuals that transitioned to the community passed away since the last onsite review. Of these, there was an adequate review conducted to determine if changes in the referral and transition planning processes at the facility should be made for (%) of the cases. Of these reviews, actions were recommended in ___ cases. Of these cases, actions were implemented for ___ (%). Other Adverse Outcomes: f. Over the past six months, 4 of the 23 individuals placed in the past year (17%) experienced one or more potentially negative outcomes since placement. Of these, there was an adequate review conducted for 0 (0%) of the cases to determine if changes in the referral and transition planning processes at the facility should be made. Of these reviews, actions were recommended in n.a. cases. Of these n.a. cases, actions were implemented for (n.a.) (%).	
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	Annual narrative by facility a. The facility did not have an adequate system to collect information about obstacles to transition. • The APC reported that she and the transition specialists had recently reviewed a set of 46 ISPs to see if there were obstacles identified, if obstacles were addressed, and if the obstacles in the state's Avatar database system matched what was in the ISP. She found that only about 30% obstacles stated in the ISP matched what was in the database. There were other problems, too, such as the database indicating LAR preference as the obstacle to referral for individuals who did not have an LAR. She planned to correct this by working with the QIDP coordinator. It was good to see that the APC was working on this. • The monitoring team also found that obstacles were not adequately identified in the ISPs. Thus, the data in the facility's system were even more suspect (see T1a). • The data in the report did not match other data submitted by the facility	Noncompliance

	serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	(e.g., LAR reluctance, individual reluctance) or appeared to be incomplete (e.g., table 4). • The facility's data system, when completed, should also indicate if any "compromises" of the individual's needs, preferences, and/or supports were required in order for the transition to occur. An example of a compromise would be if the individual "settled" for a day habilitation program because the vocational program that the team recommended (or that the individual preferred) was not available in the part of the state in which the individual/guardian wanted to live. Another example would be if the individual moved to an area of the state that was not the original preference because clinical services were not available there. b. The facility did not have an annual narrative that showed it had (a) conducted a comprehensive assessment of obstacles, and (b) developed and implemented appropriate actions to address and overcome these obstacles on the local level within the authority of and resources available to the Facility. • The narrative included strategies to address both sets of obstacles (referral and transition), however, for most of the obstacles to transition, the report only described the problem. The report did not lead to new or general strategies to address the types of obstacles to transitions for individuals who were already referred. • The APC reported that access to psychiatrists and access to appropriate employment and day programs were obstacles. The facility did not have a plan to try to address these important obstacles. Annual narrative by DADS state office c. The State did not present an annual narrative that showed it had (a) conducted an analysis of the Facilities' data, (b) taken 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, and (c) as appropriate, DADS made efforts to seek assistance from other agencies or the legislature. DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/13 from all 13 Facilities. The report was issued to the Monitors and DOJ on 3/27/14, seven months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 6 obstacles to referral categories and 12 obstacles to transition areas used in FY13. • DADS included a list of 14 initiatives it was continuing to support. • The report included attachments with each of the Facilities' annual reports.	

		• The validity of the obstacles to referral data appeared to be more accurate than in previous years' reports. However, as noted in the monitoring team's reports, concerns still existed with teams' accurate identification of obstacles. The following concerns were noted with regard to the report: • Transition obstacles data: Adequate methodologies were not described as to how data regarding obstacles to transition were determined and collected. For example, it was not clear if one individual could have had more than one obstacle, and/or if different obstacles presented themselves at different times during the transition process. Further, the data should describe whether these obstacles to transition were overcome. As a result, the validity of the data provided in the report was questionable. Further, it would be useful to formalize the process to identify obstacles far ahead of the 180-day goal (i.e., not wait until 180 days have passed before identifying and documenting obstacles). o State office staff reported during recent discussion with the Monitors, that anytime the IDT identified an obstacle to transition, it should be included into the database. Further, state office staff said that their data system allowed for an individual to have more than one obstacle to transition and indeed many individuals did have more than one obstacle in the data. The data system, however, did not track, or report on, whether obstacles were successfully addressed (i.e., whether the individual had not yet moved and/or whether compromises had to be made). The monitoring team believes that this information should be included in the report. • DADS strategies: DADS included a list of strategies and actions, however, they did not thoroughly address some of the most frequently cited obstacles that the Facilities had identified. For example, according to the 2013 Annual Obstacle Report Data spreadsheet, 353 individuals were not referred due to "Behavioral health/psychiatric needs requiring frequent monitoring...," 308 individuals were not referred due to "Medical needs requiring 24-hour nursing…," and 1698 individuals were not referred due to "LAR's reluctance for community placement" (almost 50% of the population of all of the facilities). Most of the 14 strategies/actions described general activities, such as to improve the ISP process, the coordination of transition activities, data collection, or special projects at Austin SSLC. Although these appeared to be worthwhile activities, few strategies specifically addressed the above three categories: behavioral/psychiatric (strategies 7 and 8), medical-accessibility (strategies 9 and 10), and LAR preference (perhaps strategies 1 and 12b). Moreover, given that many of the strategies were repeated (or slightly modified) from last year's report, an update on the status of each would be appropriate to include in this report. o During recent discussion with state office staff, the staff agreed that	

		better overall analysis was needed in order to tie identified obstacles to their set of statewide strategies (and/or to ensure that there were strategies to address the most-often identified obstacles to referral and to transition). • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). o The monitoring team was unable to determine this because there was no information in the report addressing it.	
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.	a. The facility did provide an accurate Community Placement Report for six months ending on the week prior to the onsite review (9/1/13-4/27/14) that included the following information: • Number and names of individuals transitioned to the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference (there were 0 names)	Substantial Compliance

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.	SASSLC maintained substantial compliance with this provision item. Overall, post move monitoring was done thoroughly and competently. Follow-up occurred when needed. Providers responded and individuals were doing very well in the community. The PMM was responsive to comments and recommendations from the last onsite review and monitoring report. Since the last review, 29 post move monitorings for 13 individuals were completed. This compared to 36 post move monitorings for 16 individuals, 29 post move monitorings for 11 individuals, and 3 post move monitorings for 3 individuals at the time of the last reviews. The monitoring team reviewed completed documentation for 14 post move monitorings for 13 different individuals. Of the 14 post move monitorings, 13 were completed by the post move monitor Darlene Morales, and 1 by Tania Fak, APC. Rather than submitting every post move monitoring report, the facility submitted the most recent one completed (i.e., the 90-day for 8 of the 13 individuals, the 45-day for 3 individual, and the 7-day for 2 individual). Because the reports were completed in a cumulative manner, they contained information from the previous reports (i.e., the 90-day included findings and comments from the 7-day and 45-day). In the future, however, the monitoring team requests that all of the reports be submitted because some information is not carried forward (e.g., staff interviewed, locations visited, dates and times). <u>Timeliness of Visits</u> For the 13 individuals, 29 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 29 required visits, 29 (100%) were conducted and 29 (100%) were completed on time. Of the 14 post move monitoring forms reviewed by the monitoring team (for 13 different individuals), all 14 (100%) included dates showing that they were completed on time. <u>Locations visited</u> For the 14 post move monitorings reviewed, 14 (100%) indicated that the PMM visited	Substantial Compliance

		the locations at which the individual lived and worked/day activity (e.g., day program, employment) were visited. <u>Content of Review Tool</u> 14 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. The PMM used the newest iteration of the form for the most recent of these post move monitorings. The post move monitoring report forms were completed correctly and thoroughly, as follows • The checklist was completed in a cumulative format across successive visits for 13 of the 13 (100%) 45- and 90-day visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 14 of the 14. o The PMM should now provide detail in her report regarding: ▪ Whether she had evidence of all aspects of required training and inservicing, such as who, what, how, and documentation of competency (rather than merely stating training documentation was reviewed). ▪ The post move monitoring form had a column labeled "Evidence reviewed." However, what the PMM entered into this column was the evidence that was "to be reviewed," copied directly from the CLDP. Then in her narrative, she usually, but not always, noted what evidence she looked at. In most cases, it was the same evidence that she had entered into the evidence reviewed column. • The monitoring team recommends that the PMM clear up this confusion. It is fine if she wants to continue to copy the evidence from the CLDP into the evidence reviewed column. If so, she needs to be sure to describe, in the narrative detail, all of the evidence that she actually looked at. This should include all of the evidence that the CLDP required her to look for, as well as any additional evidence (e.g., interviews, documents, observations) she examined. • Each post move monitoring included a review of all pre move supports (as it should). The yes/no boxes were marked in each post move monitoring report. • There was adequate justification for findings for each support in 14 of the 14 (100%). • Detail/comment was included in 14 of the 14 (100%) reports for every support. • LAR/family satisfaction with the placement and the individual's satisfaction	

		were explicitly stated in 14 of 14 (100%). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements was provided by the PMM in 14 of the 14 (100%). o These were well written and very helpful to the reader. • 10 of 14 reports (71%) indicated the specific name and title of each person interviewed by the PMM. This did not occur in the four oldest of the reports, that is, those that were done on the previous iteration of the post move monitoring report form. The 10 newest reports contained this information. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 13 individuals who received post move monitoring, 11 (100%) transitioned very well and appeared to be having good lives (2 of the 11 had some difficulties during the first couple of months). Regarding the other 2 individuals, 1 had returned and the other 1 was having problems at his current placement. His provider was transferring him to a different home (Individual #140). As discussed with the APC, a root cause type of review needs to be done for any individuals whose placements failed or who had the kinds of problems noted in T1f. <u>Use of Facility's best efforts when there are problems that can't be solved</u> In 3 of the 14 post move monitorings (21%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 3 of the 13 individuals (100%). The problems were of a serious nature: aggressive and self-injurious behavior, approaching high school students in the community, inappropriate social boundaries and possible inappropriate sexual behavior. The PMM contacted the provider, IDT, and ensured follow-up occurred. Moreover, following the post move monitoring observed by the monitoring team, the PMM followed-up with state office, the IDT, provider, and advocate regarding the many problems with Individual #140's placement. <u>ISPA meetings after post move monitoring visits</u> An ISPA meeting should occur after every post move monitoring during which a problem or concern was noted by the PMM. An ISPA meeting was to be held and there were to be minutes/documentation of the meeting following post move monitorings for which an ISPA was appropriate to have been held. An ISPA meeting was necessary for 2 of these 13 post move monitorings and was held for 2 of the 2 (100%).	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying	SASSLC maintained substantial compliance with this provision. The monitoring team observed one post move monitoring at the apartment of Individual #140 for the 90-day review. The PMM, Darlene Morales, did a thorough and complete	Substantial Compliance

	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.	job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual interview • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information The PMM's report was an accurate reflection of what was observed by the monitoring team. However, for some supports, she noted that the individual was not complying. If as a result, the individual does not receive the support, it should be rated as a no. Ms. Morales scored some of these as yes, but even so, she engaged in follow-up activities. Her follow-up included contact with her supervisor, state office, the provider, advocate, and the SASSLC IDT. The provider was Just Like Home Centers. Individual #140 was not doing very well at home. He was observed smoking in a non-smoking area of the apartment complex, being out of line of sight supervision from apartment staff, and he was non-responsive to questions from the PMM. Further, the provider staff reported occurrences of behavior problems, including inappropriate interactions with women at the apartment complex. The home and bedroom were spartanly furnished. The apartment, although clean, needed painting, air conditioner filters cleaned, and window blinds repaired. The individual's bedroom was messy and he reported that there were bugs, which was confirmed by the provider. The one staff member present was knowledgeable of the individual's need, preferences, and supports. The PMM reported that she was going to follow-up with the APC and the owner of the agency the next day. The PMM reported that the provider was planning to have the individual move from this apartment to one of their group homes. The monitoring team was quite concerned about the stability of this placement and the potential for problems with neighbors. The monitoring team raised this concern to DADS state office following this post move monitoring visit.	

T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations	This item does not receive a rating.	
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	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. No individuals were listed as being discharged as per section T4.	Not Rated

SECTION U: Consent	

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The parties agreed the monitoring team would not monitor this provision, because the facility had made limited to no progress. The noncompliance finding from the last review stands items.	Noncompliance

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o SASSLC facility-specific policies: • Recordkeeping practices, updated 8/20/13 • Master record procedure, updated 6/4/13 • Acknowledgement Form Procedure, updated 5/20/13 • Physician master signature list, 8/18/13 • Monthly record review, 10/14/13 • Medical travel packets, 8/20/13 • Active records checkout procedure, 8/20/13 o SASSLC organizational chart, undated but likely February 2014 o SASSLC policy lists, undated, 2/15/14 o List of typical meetings that occurred at SASSLC, undated but likely February 2014 o SASSLC Self-Assessment, 4/17/14 o SASSLC Action Plans, 4/17/14 o SASSLC Provision Action Information, 4/1/14 o SASSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/28/14 o List of all staff responsible for management of unified records o Description of changes since the last onsite review (regarding ISP documents) o List of other binders or books used by staff to record data o Description of the shared drive o Tables of contents for the active records 7/11/13, individual notebooks 3/20/14, and master records (July 2013) o New admissions unified record checklist, through 3/31/14 o Example of an inservice, 3/14/14 o ISP document submission tracking, most recent entries dated 4/25/14 o Recordkeeping QAQI Council presentation materials, November 2013 and January 2014 o QA report for section V, March 2014 o Policies listed by Settlement Agreement provision, 4/1/14 o Policy review committee meeting log, most recent entry 3/20/14 o Description of the unified record audit process o Blank unified record audit tools, new, March 2014 o List of individuals whose unified record was audited by the URC, October 2013-March 2014 o Completed audits for 11 individuals, January 2014 (old format) and February-March 2014 (new) • 16-18 page audit tool for active record, individual notebook, and master record

	○ Medical consultation tracking sheet used for doing audits, March 2014 ○ Blank inter-rater tool, revised, February 2014 ○ Notification emails for the 11 audits ○ Follow-up tracking for audits done in December 2013 to February 2014 ○ Blank V4 interview tool, and two completed interviews in March 2014 ○ Active records and/or individual notebooks of: • Individual #264, Individual #4, Individual #86, Individual #122, Individual #226, Individual #45, Individual #260, Individual #176, Individual #39, Individual #118, Individual #112 ○ Master records of: • Individual #24, Individual #301, Individual #321 <u>Interviews and Meetings Held</u>: ○ Noemi Cardenas, URC ○ Janet Prince-Page, Coordinator of Unified Records ○ Various DSP, nursing, and management staff <u>Observations Conducted</u>: ○ Records storage areas in residences ○ Master records storage area
	Facility Self-Assessment The monitoring team again recommends that the self-assessment contents line up directly with the contents of the monitoring report. That is, there should be a self-assessment of each aspect of each of the four provisions of section V that the monitoring team comments upon (e.g., active record, individual notebook, master record, existence of policies, training on policies, components of the V3 audit, implementation of the audit, presentation of results, follow-up, each V4 component). V1 of the self-assessment reported only on the quality-related aspects of IPNs, physicians' orders, and observation notes. The monitoring team looks at a variety of other aspects of recordkeeping practices when rating V1. This is evident in the report below. For V3, the self-assessment reported on the results of the quality assurance audits, but those data should be part of V1. Instead, the URC should assess the quality of the audit process and its resultant data analysis and quality improvement actions. The facility self-rated itself as being in noncompliance with all four provisions of section V. The monitoring team agreed.

	Summary of Monitor's Assessment: SASSLC made progress in some areas of section V and maintained status in other areas. Fourteen of 14 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions. The status of the active records maintained since the last review. The monitoring team's onsite review of active records showed about 10 errors/missing documents per active record, plus there were errors in legibility, signatures, etc. This was similar to what was found by the URC in her own audits. Most frequently missing documents were quarterly medical summaries, SAP progress notes and data sheets, and ISP monthly reviews. A number of types of daily data regarding individuals was no longer in the individual notebook, but were instead in different binders. The URC needs to incorporate this information into her monthly audits. A master record existed for every individual at SASSLC and all were in a format that was organized, manageable, and described in previous reports. The CUR, who was responsible for the master records, had not continued to implement the system of making entries onto the blue page to indicate what efforts had been taken to obtain any missing documents. No progress was made on section V2. Five quality assurance audits were done in five of the past six months. Beginning in February 2014, the URC began using the new 16-page tool that she developed. It incorporated the previous table of contents tool and statewide tool. The system of actions following the conduct of the audits remained the same. An email was sent to each responsible person. There was no indication of any other follow-up activity or any data to indicate if this problem was getting better or worsening. The URC summarized her data in her monthly QA report. The monitoring team has made comments regarding the inadequacy of some of these data in providing an understanding of the status of the unified record and setting the occasion for analysis and actions. Further, there was no analysis of the data that were being summarized. For section V4, some changes were made to the interview tool, but overall, no progress was made towards substantial compliance.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SASSLC made progress in some areas of section V and maintained status in other areas. To conduct this review, the monitoring team examined aspects of the unified record for more than a dozen individuals, reviewed documents and reports, talked with various staff at the homes and day programs, and observed records in use, in the program sites, and during various meetings. State policy remained the same as in previous review. The overall facility-specific recordkeeping policy also remained the same. The facility's list of policies, however, had a number of different policies related to section V. The URC should either correct this list or be certain to present this set of policies at the next onsite review. The monitoring team made this comment in the last report, but no changes were made. The table of contents and maintenance guidelines for all three components of the unified record were last updated in July 2013, with a minor change to the individual notebook table of contents in March 2014. The URC actively participated in the facility's QA program. This included completing a quarterly QA report. Fourteen of 14 (100%) individuals' records reviewed included an active record, individual notebook, and master record. A unified record was created for all new admissions. <u>Active records</u> The status of the active records maintained since the last review. The monitoring team reviewed active records in four of the homes, covering all three of the units and the work of four different record clerks. The URC and CUR engaged in a number of activities to increase the likelihood of the unified record meeting substantial compliance. Some of these activities had been occurring for a number of years. Each should be evaluated for the purposes of continuous quality improvement. • There was a physicians' signature sheet that allowed the reviewer of the IPNs to more easily determine the physician's entries. • An SAP policy that described how SAPs were to make their way into the active record was implemented. • The submission of ISP documents to the record clerks continued. • 24 hour record checks were done by the nursing department. • An active record check out system was put into place (see V4 #1 below).	Noncompliance

#	Provision	Assessment of Status	Compliance
		• V3 audits continued (see V3 below). Recordkeeping practices were no longer a part of NEO or annual refresher training, and the URC was no longer doing any staff training or inservices, though there was one occurrence of an inservice with nursing staff regarding IPN requirements on 3/14/14. The CUR, URC and QA director should discuss this because it seems that some level of ongoing training should be occurring. The monitoring team's onsite review of active records showed about 10 errors/missing documents per active record, plus there were errors in legibility, signatures, etc. This was similar to what was found by the URC in her own audits (see V3) based upon the monitoring team's review of the sample of audits. The URC's data, however, were presented only as a percentage of all items correct, rather than showing the actual number of errors found (this was a comment in the last monitoring report, too), making it impossible to determine the number and types of errors. Some additional comments regarding the active records: • The URC had done some counting of IPN, physician orders, and observation note entry errors. She did not, however, have a valid way of determining if the errors were improving or getting worse, in part, because of the overall number of entries. Even though she reads three months of these sections of the active record, she might consider having her data be based upon a sample of these entries. She should work with the QA director on a solution to this. • Many documents were out of date as per the guidelines; many were more than a year old. This was across various aspects of the active record, such as assessments, consents, and treatment plans. • Most frequently missing documents were quarterly medical summaries, SAP progress notes and data sheets, and ISP monthly reviews. • PSPs were filed under the psychiatry tab. The monitoring team suggests that a pointer page be placed in the behavioral health tab that notifies the reader that indeed there is a plan for behavioral and psychiatric issues, even though there is no PBSP. • The monitoring team and the URC were confused by there being two lines in the psychiatry tab that seemed to be duplicative: psychiatric assessment and psychiatric evaluation/consultation. • It seemed that many items in the table of contents guidelines should be asterisked, such as code status and Reiss screens.	

#	Provision	Assessment of Status	Compliance
		Individual notebooks Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. Individual notebook carts continued to be used, as noted in the previous report. At SASSLC, individual notebook management was the responsibility of the home supervisors. IHCPs were not in the individual notebooks, but should be. Overall, the content of the individual notebooks was appropriate and complete. Timely recording of behavior data, although recorded in another binder, had increased to 48% from 14%. Some documents were present that did not belong in the individual notebook, such as the permanency plan for Individual #118. The URC was not aware if the unit directors were still doing an individual notebook review each day, or if the daily individual notebook transport to day program log was being used. Her plan to do daily checks on the presence of individual notebooks and active records was never initiated. Other binders/logs: A number of types of daily data regarding individuals was no longer in the individual notebook, but were instead in different binders, k This included day program skill acquisition plan and PBSP data, and residential diet treatment records and PBSP data. This is fine to do, especially if it increases the likelihood of timely and accurate data collection. The URC, however, needs to incorporate this information into her monthly audits. Master records A master record existed for every individual at SASSLC and all were in a format that was organized, manageable, and described in previous reports. Each record contained a blue page that detailed what was present and what was missing. Overall, the master records were in good shape. The URC pointed to a recent success in obtaining Medicaid cards for 55 individuals. Unfortunately, the CUR, who was responsible for the master records, had not continued to implement the system of making entries onto the blue page to indicate what efforts had been taken to obtain any missing documents. This should be started again. She does not need to go through every master record, but at a minimum, should do so as part of the set of monthly quality assurance audits done by the URC. Shared drive The shared drive was described to the monitoring team. The recordkeeping department	

#	Provision	Assessment of Status	Compliance
		reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	

V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	SASSLC had not progressed towards substantial compliance with this provision. Therefore, the monitoring team repeats the comments made in the previous two reports:
		
		SASSLC maintained the same spreadsheet as during the last onsite review. It had been recently updated.
		
		Not all state policies were in place yet, though continued progress was evident.
		
		For the next onsite review, the facility should specify for the state and facility policies for each provision of the Settlement Agreement, regarding training:
		• Note the list of job categories to whom training should be provided.
		• Define, for each policy
		  o who will be responsible for staff training,
		  o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and
		  o documentation necessary to confirm that training occurred.
		(Some of this responsibility may be with the Competency Training Department.)
		• Include timeframes for when training needed to be completed and re-implemented. Some trainings occur only once, while others require annual refreshers.
		• Include a system to track which staff completed which training.
		• Include data on the number of staff who are supposed to receive training on each and every policy and the number of staff who did receive training on each of these policies. Then, a percentage can be calculated.
		  o It would be helpful to include an "as of" date so that the reader knows that the training data were valid/correct as of a certain date.
			Noncompliance

V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified	Five quality assurance reviews (audits) were not conducted in each of the previous six months. Only one review was conducted in November 2013, however, five were conducted in each of the other five months. Thus, 26 audits were conducted in the previous six months. All of the reviews were done in a consistent manner. Beginning in February 2014, the URC began using the new 16-	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	page tool that she developed. It incorporated the previous table of contents tool and statewide tool. The URC reported that each audit took four to six hours to complete. The review consisted of these parts: • The unified record audit tool. It was 16 pages long. In the new tool, quality-related Appendix D items were inserted under the IPN, physician's orders, and observation notes sections. This was a reasonable way to get at these aspects of recordkeeping. • Detailed reading and review of three months of observation notes and IPNs to inform her review. If she found five or more errors in any category (e.g., legibility, signatures), that item was scored as a no. • Checking for documentation of medical consultations for the past 12 months. • A unified record was not audited if it had been audited in the previous 12 months. Moreover, the URC did not audit any individual's record who had his or her annual ISP in the previous three months. In this way, she would be assured the ability to review at least one-quarter's worth of documents. Interobserver agreement was conducted, but there were some problems with the way it was being done. First, it should be conducted on the entire tool, not only on a portion. Second, if agreement is found to be high, it would be acceptable to reduce the amount of interobserver checks to one per month. The system of actions following the conduct of the audits remained the same. It consisted of the following: once completed, the URC color-coded the table of content audit reports with each color representing a different department. Then, she emailed the color-coded reports to all relevant departments with a request for corrections to be made. Then, over the subsequent two months, she handwrote on the same audit report to indicate as each item was corrected. She used a checkmark to indicate corrected or wrote a short note the status. If errors were not corrected, she further followed-up with emails to department heads. Many errors were noted as corrected, but a large number remained uncorrected. There was no indication of any other follow-up activity or any data to indicate if this problem was getting better or worsening. The URC summarized her data in her monthly QA report and quarterly QAQI Council presentation. The data were presented in the same format for the past few years. The monitoring team has made comments regarding the inadequacy of some of these data in providing an understanding of the status of the unified record and setting the occasion for analysis and actions. Further, there was no analysis of the data that were being	

#	Provision	Assessment of Status	Compliance
		summarized. The overall data system, review of data, and analysis of results needs to be improved in order to meet substantial compliance with this provision. At a minimum, the CUR and URC should have and present data that include: • New unified record tool: month to month graphs showing long term performance scores. • Number of errors: month to month (perhaps separately number of missing documents, number of out of date documents, number of needing-purged documents, and so forth. • Number/percentage of documented errors that were corrected. • Master records: number of missing documents that were not yet resolved. • Various data related to V4 (once those activities are better defined).	
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.	There are six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URC. Some changes were made to the V4 interview tool, but even so, no progress was made towards substantial compliance with this provision. The monitoring team recommends that the URC and CUR collaborate with other SSLCs and with state office. They should consider how to use data from V1 and V3 to assess aspects of V4, how to incorporate some of the data and information needed for V4 into their V3 audits, collecting and summarizing/graphing data for each of the V4 components, and including V4 data and information in their QA activities, QA report, and presentations to QAQI Council. Moreover, they should keep in mind that V4 requires more than self-assessing, that is, it also requires that facility "utilize such records in making care, medical treatment and training decisions." The facility was in substantial compliance with none of the six items (0%) Below, the six areas of this provision item are presented, with some comments regarding SASSLC's status on each. <u>1. Records are accessible to staff, clinicians, and others</u> An active record check out system was put into place, but was not working very well and was not being monitored. The monitoring team looked at the check out binder and sign out sheets in each home. For example, in home 672, at 5:00 pm one afternoon, some	Noncompliance

#	Provision	Assessment of Status	Compliance
		active records were missing, but were not signed out, and some active records that were signed out, were present. In other words, there was 0% accuracy. Data on the availability of the active records and the accuracy of the check out log is one type of information that could be collected by the facility to monitor this aspect of V4. Another could be the presence/availability of individual notebooks. Record accessibility during meetings is addressed in item #6 below. The monitoring team also observed that: • A sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current ISPs were available in all individual notebooks, however, IHCP were not filed as part of the plan and not available in individual notebooks. Without the IHCPs accessible to direct care staff, they did not have information necessary to ensure supports were in place to address identified risks. • Nursing records were available and accessible to staff, clinicians, and others when needed. The monitoring team reviewed Individual #3's record onsite and found the IPN notes, ACP, IRRF and IHCP present in the chart. • DSPs used individual notebooks and new data notebooks. They were generally accessible to DSPs. • Habilitation therapy staff documented consistently regarding all supports, services, and interventions in the IPNs and SAPs. <u>2. Data are filed in the record timely and accurately</u> For this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). SASSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews could be used to satisfy this aspect of V4, too. In addition, they might consider doing an occasional comparison of what is in the electronic shared folder (which probably contains the most recent documents) to see if what is in the active record corresponds to what is in the shared folder. The monitoring team also observed that: • The facility had begun gathering data on the submission of ISPs for the	

#	Provision	Assessment of Status	Compliance
		individual records. A list provided by facility reported that only 41% of the ISPs developed between September 2013 and February 2014 were filed within 30 days after the annual ISP was held. Again, this was problematic because staff responsible for implementing the ISP did not have access to current plans. • Target/replacement behaviors were recorded in data books at each home and day treatment site. Timely recording of target behaviors was improving. • SASSLC was not collecting data reliability. • SAP data were recorded in the individual records, and were often not accurate. • Findings of habilitation therapy effectiveness monitoring were documented on a separate form with little evidence noted in the IPNs. • Individual #333's record did not include the accompanying Quarterly Nursing Physical assessment. • Individual #87's seizure record had omissions for recording the vital signs. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The monitoring team observed that: • At both ISP meetings observed, data were unavailable for many of the outcomes implemented over the past year. Thus, IDTs were unable to determine if supports were effective or needed to be modified. • 48% of data sheets reviewed by the monitoring team were recorded in a timely manner • The clinicians consistently used a combination of data sheets, weekly IPNs, and monthly summaries to consistently document direct supports and services. • Data were up to date when presented to psychiatry, and graphs were improved and easier to interpret. There was a need for improvement with regard to the identification of target symptoms for monitoring that would allow for a determination of medication efficacy such that data driven decisions can be made regarding the individuals psychopharmacological regimen. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The monitoring team observed that: • A review of an acute event for Individual #38 documented the nurse had reported to the physician the individual's change of health status, for which treatment was ordered. An IPN nursing note was not found in the record that the physician was called with the assessment. • Effectiveness monitoring was routinely documented on a monitoring form to determine if the supports were addressing the identified need (PNMP), but there was little evidence of this in the IPNs.	

#	Provision	Assessment of Status	Compliance
		5. Staff surveyed/asked indicate how the unified record is used as per this provision item The URC began to again implement the staff interview for two staff each month. In addition, the monitoring team observed that: • During the Yellow Flag Committee, nurses were asked how they use the unified record to make care treatment and training decisions. The responses from the nurses were consistent that they used the record to review what was written by the previous nurse, and to gather information from the unified record to establish a SBAR (a communication process used at SASSLC to ensure continuity of obtaining historical and current information). Examples included allergies, medications, recent changes in medication, vital signs, and nursing assessment of systems. The information in the SBAR was then documented in the chart and/or physician was notified of the SBAR. • The unified record was present during a Yellow Flag Committee meeting and used to review the IPNs and ACPs for Individual #3. • The unified record was present during an ISP meeting for Individual #261, which was referenced only after questions were raised regarding the individual's diagnosis and associated assessments where the IDT team appeared unaware of the documented diagnosis. 6. Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions The intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. The monitoring team found the following: • The QIDP facilitator provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #337 and Individual #90. Data from assessments were entered into these two forms, so that team members could reference current assessments when developing necessary supports. The unified record was available at the meeting and was used by the team when additional information was needed. o The IDTs at both meetings, however, questioned the accuracy of some of the assessment information presented. Both teams requested further assessment to clarify the need for supports. • Pre-ISP meetings were observed for Individual #255 and Individual #12. The	

#	Provision	Assessment of Status	Compliance
		QIDP used information in the unified record to update IDT members to determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • Records were accessible to the psychiatrist during clinic. However, with regard to MOSES and DISCUS assessment results, previously, these were stored in Avatar with a paper document to allow for review during clinic. During this monitoring visit, paper documents were not available in clinic, impeding the review at that time. This issue must be addressed because the facility did not have the IT infrastructure to allow the psychiatrist to review these documents electronically during the clinic. • Individual records were used before, during, and after the PNMT meetings for review of status and documentation of interventions, supports, and recommendations.	

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
AAUD	Administrative Assistant Unit Director
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ABX	Antibiotics
ACB	Anti Cholinergic Burden
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ACS	Assessment of Current Status
ADA	American Dental Association
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
ADS	Annual Dental Summary
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AHA	American Heart Association
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase

APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ART	Administrative Review Team
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BHS	Behavioral Health Services
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee

BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CMD	Choking, Modified Barium Swallow Study, and Dysphagia Committee
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CMS	Circulation, Movement, and Sensation
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
COS	Change of Status

COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CPT	Certified Pharmacy Technician
CPT	Certified Psychiatric Technician
CMQI	Continuous Medical Quality Improvement
COS	Change of Status
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DBW	Desirable Body Weight
DC	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDI	Drug Drug Interaction
DDS	Doctor of Dental Surgery
DERST	Dental Education Rehearsal Simulation Training
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNP	Doctor of Nursing Practice
DNR	Do Not Resuscitate

DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPN	Dental Progress Note
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EC	Enteric Coated
EC	Environmental Control
ECG	Electrocardiogram
ED	Emergency Department
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENE	Essential Nonessential
ENT	Ear, Nose, Throat
EOC	Environment of Care
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar

FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GA	General Anesthesia
GAD	Generalized Anxiety Disorder
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
GI	Gastrointestinal
GIB	Gastrointestinal Bleed
GIFT	General Integrated Functional Training
GM	Gram
GYN	Gynecology
H	Hour
H&P	History and Physical
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride
HCV	Hepatitis C Virus
HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus

HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HOBE	Head of Bed Evaluation
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IA	Intelligent Alert
IAR	Integrated Active Record
IC	Infection Control
ICA	Intense Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
ID	Intellectually Disabled
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
IHCP	Integrated Health Care Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
IRT	Incident Review Team

ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
JNC	Joint National Committee
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LLL	Left Lower Lobe
LOC	Level of Consciousness
LOD	Living Options Discussion
LOI	Level of Involvement
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LTBI	Latent TB Infection
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCC	Medical Compliance Coordinator
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan

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

NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NFS	Non Foundational Skills
NGA	New Generation Antipsychotics
NHLBI	National Heart, Lung, and Blood Institute
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
OH	Oral Hygiene
OHI	Oral Hygiene Instructions
OHI	Oral Hygiene Index
OIG	Office of Inspector General
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
PA	Physician Assistant
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PAI	Provision Action Information
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention

PCN	Penicillin
PCP	Primary Care Physician
PD	Program Developer
PDD	Pervasive Developmental Disorder
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
PEG	Percutaneous Endoscopic Gastrostomy
PEMA	Psychiatric Emergency Medication Administration
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team
PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMR	Protective Mechanical Restraint
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
PNE	Pneumonia
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMPC	Physical and Nutritional Management Plan Coordinator
PNMT	Physical and Nutritional Management Team
PO	By Mouth (per os)
POC	Polypharmacy Overview Committee
POI	Plan of Improvement
POC	Polypharmacy Oversight Committee
POT	Post Operative Treatment
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee

PRN	Pro Re Nata (as needed)
PSA	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PUSH	Pressure Ulcer Scale for Healing
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QIDP	Qualified Intellectual Disabilities Professional
QMRP	Qualified Mental Retardation Professional
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RBBB	Right Bundle Brach Block
RD	Registered Dietician
RDH	Registered Dental Hygienist
RLL	Right Lower Lobe
RML	Right Middle Lobe
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out

ROM	Range of Motion
RPH	Registered Pharmacist
RPN	Risk Priority Number
RPO	Review of Physician Orders
RPO	Rights Protection Officer
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SBO	Small Bowel Obstruction
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIDT	Special Interdisciplinary Team
SIG	Signature
SIS	Second Injury Syndrome
SIT	Skin Integrity Team
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
STAT	Immediately (statim)

STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCA	Texas Code Annotated
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TFT	Thyroid Function Tests
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TLSO	Thoracic Lumbar Sacral Orthotic
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSHA	Texas Speech and Hearing Association
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
UR	Unified Record
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VAP	Vascular Access Port
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device

VP	Ventriculoperitoneal
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
VZV	Varicella Zoster Virus
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old