#	Plan Requirements	Glenwood Resource Center Oct, Nov 2008 Tours	DOJ Assessment
	(Note that SRC paragraphs below are summarized and/or abbreviated to accommodate size of chart. No text in this chart is meant to augment or replace the actual language and requirements of the SRC Plan)		
III. PROTECTION FROM HARM			
A. RESTRAINTS			
1	Prohibit prone restraints		
2	Restraints permitted only in emergency situations & not as a substitute for training		
3	Policies/staff training/desensitization programs as needed		
4a	Identify persons restrained in last 12 mos	Individuals receiving restraints are identified on an on-going basis in the restraint tracking system.	C
4b	Complete CFA on persons identified above	A functional analysis has been done for all individuals who have received restraints.	C
4c	Develop/implement BSPs for above persons; BSPs must contain min elements*	BSPs at GRC do not include programmatic restraints.	N/A
5a	No restraints when prohibited by ISP or medical orders		
5b	Begin face to face observations by RN w/i 30 mins of restraint		
5c-i	Person in restraint shall monitored/examined/released in accordance with plan		
5j-l	Restraints will be documented according to plan	The standard format for BSPs identifies the person responsible for the plan and the staff authorized to implement; also included is a description of the frequency and manner of data collection required.	C
6	BSP reviewed and/or revised when >3 restraints occur within 4 wks	Dr. Taylor conducts QA event-based reviews of individuals who have had three restraints in four weeks, focusing on the adequacy of psychologists' documentation. Dr. Taylor also reviews time out logs and provides feedback regarding procedure and documentation. There appears to be adequate evidence that, when an individual experiences three restraints in a four-week period, the BSP is reviewed and revised as appropriate.	C
7	Each restraint reviewed w/i 3 busn days by IDT		
8	Competency based restraint training for all staff		

IV. INTEGRATED PROTECTIONS, SERVICES, TREATMENTS & SUPPORTS

A. INTERDISCIPLINARY TEAMS

1	IDT shall seek personal independence/choice/quality of life	ISPs are improved with respect to facilitating choice, enhancing independence, and supporting self-determination. The peer review and team performance monitoring processes in place are having a positive effect with respect to this provision. Data are being collected with respect to the provision; however, these data are not yet being analyzed and interpreted, nor do they yield QA action plans for continuous quality improvement. This system appears adequate to provide teams with meaningful recommendations and individual feedback has been given but data are not yet being used to identify trends over time or systemic problems, nor are there action plans to address such trends or problems.	C
2	QMRP ensures assessments & services are adequately provided	There have been good improvements in interdisciplinary team functioning. A good MIR was observed during the tour. A monitoring system is in place to assess team members' participation, data are routinely being collected, and a monthly summary report has been produced for the most recent month. This system appears adequate to provide teams with meaningful recommendations and individual feedback has been given but data are not yet being used to identify trends over time or systemic problems, nor are there action plans to address such trends or problems.	C
3	IDT = Person, QMRP, guardian & others as needed	The ISPs generally document efforts to engage guardians in annual reviews. Individuals did not participate in the MIR observed during the tour (held during school hours, individuals were school-age and did not wish to miss school). I encourage the facility to consider how to include individuals in the review process if they cannot attend the meeting.	C
4	Assess when needed, to ID strengths, preferences, needs	Annual assessments are routinely included in the ISP and appear to address significant changes in the individual's life, strengths, preferences, and needs.	C
5	ISP, w/supports & protections, based on assessments	The Comprehensive Functional Assessment is being routinely used to assist in selection of appropriate goals and objectives and to prioritize them. Data provided by Dr. Taylor indicate a significant increase in special IDT meetings for the period July-September 2008, compared to the same time period in 2007. This increase suggests improved IDT attention and responsiveness to significant events. Chart reviews indicate more frequent ISP revisions in response to assessment results. Data on the implementation and use of the CFA are being generated. This system appears adequate to provide teams with meaningful recommendations and individual feedback has been given but data are not yet being used to identify trends over time or systemic problems, nor are there action plans to address such trends or problems.	C

B. INTEGRATED SUPPORT PLANS			
1	Policies/procedures requiring ISPs be consistent with standards of care	ISP policy appears appropriate.	C
2a, b	ISP quality will be consistent with professional standards of care	The ISPs adequately identify strengths, needs, preferences, and desires. The person centered planning process appears to build into the development of the ISP support for choice, independence, and self-determination. There has been improved emphasis on addressing the big picture when it comes to integrating assessment data into a package that moves people toward their long-term goals.	C
2c	ISP to identify measurable beh goals, supports to attain, & barriers	The habilitation plan includes goals and objectives and strategies to be employed; supports are identified. Identification of barriers to placement and the facility's efforts to overcome those barriers are improved.	C
2d	ISP will fully integrate all protections/svcs/supports/TX plans	Integration of ISPs is improved and the peer review process should continue and sustain this improvement.	C
2e	ISP will identify methods, time frames, pers responsible	The habilitation plan identifies methods for implementation, time frames for completion, and the persons responsible.	C
2f	ISP will identify methods to implement in most integrated setting	Interventions, strategies, and supports in the ISPs are increasingly practical, functional, and integrated. ISPs are generally adequate with respect to the amount of active treatment. The facility is encouraged to develop a definition of "adequate active treatment" and to monitor ISPs and their implementation to determine whether the definition is achieved. Data are being collected with respect to the provision. This system appears adequate to provide teams with meaningful recommendations and individual feedback has been given but data are not yet being used to identify trends over time or systemic problems, nor are there action plans to address such trends or problems.	C
2g	ISP will identify data collection requirements, incl who collects & who reviews	Individual program plans generally address these points.	C
3	Goals, objectives, outcomes, services, supports, TX integrated into ISP	ISP goals, objectives, anticipated outcomes, services, supports and treatments are generally better coordinated in ISPs. Continue monitoring is warranted to ensure that progress is maintained and extended.	C
4	ISP comprehensible for the capabilities of staff responsible for implementation	ISP language is generally accessible, comprehensible and appropriate for the capabilities of the staff responsible for implementing it.	C
5	Monthly progress reviewed by appropriate IDT member (one writing each program)	MIR documentation frequently does not include reporting, analyzing or interpreting data from habilitation training programs. The Judgment of Progress Protocol is intended to address this deficit and has demonstrated good effect with respect to behavioral data; however, it has not yet been consistently applied nor has it been in place long enough to evaluate its effect with respect to habilitation training programs.	NC

6	ISP and IEPs consistent with one another	The facility appears to have in place processes for making ISPs and IEPs for school-age individuals consistent and compatible. Behavior plans appear to be adequately trained at school and such training is documented.	C
7	CBT on individualized goals for staff implementing programs	Competency-based training on the development and implementation of ISPs is in place and annual updates are occurring.	C
8	1 trainer responsible for IDT training and oversight	GRC has designated such a person.	C
9	Manageable caseloads for IDTs	The caseload for IDTs appears to be reasonable.	C
10	Implement ISP QA system to ensure B1-9 occurs & is effective	A QA process is in place and it appears to be having the desired effect of improving ISPs. There are new (September 2008) performance measures (reflected in a new QA checklist for peer review) that spell out minimum standards and best practice standards for each component of the ISP. Data are being collected with respect to the provision. This system appears adequate to provide teams with meaningful recommendations and individual feedback has been given but data are not yet being used to identify trends over time or systemic problems, nor are there action plans to address such trends or problems.	C

V. CLINICAL CARE			
A. SUPERVISION AND MANAGEMENT			
1	Structure to ensure supv/mgmt & integration; establish clinical peer reviews	Structures, although new, are currently in place to supervise, manage and integrate clinical peer reviews but need time to mature.	C
2	Rev non-SRC consultants' recs- document SRC decision to implement/not implement	Most reviews of consultants recommendations and decisions regarding implementation are done at the daily Medical/Administrative meeting.	NC, but progress noted
B. MINIMUM ELEMENTS			
1a	Timely assessment of clinical needs- regular and PRN	I checked the records of 5 individuals who returned from hospitalizations between 6/25/08 and 10/14/08): LL, CM, KH; SF; and KQ. With the exception of KH, there were appropriate nursing and physician assessment both before and after transfer to acute settings. Outcomes of these reviews indicate that for the most part assessments both before transfer and following return were done, with the exception of LL before transfer, and KH both before and after. KQ expired at the hospital.	NC, but progress noted
1b, c	Diagnoses and TX consistent with current SOC of discipline	Partial compliance. Will review at next visit when systems recently implemented have had time to mature.	NC, but progress noted
1d	Specific clinical indicators to measure efficacy		NC, but progress noted
1e	System for measuring health status consistent with current SOC		NC, but progress noted
1f	TX changes based on clinical indicators		NC, but progress noted
2	Policies/procedures requiring integration of clinical services		C

C. AT-RISK INDIVIDUALS			
	ID at-risk individuals as defined in V. C.	There are complex risk management policies and procedures in place, although I believe that two groups are being missed: Those at high risk for bowel obstruction and those with GERD, hiatal hernia and esophagitis. This is difficult to diagnose, but it is clear to me that these conditions were operational in a number of deaths in the past several years, but not adequately identified in the current risk management systems. With better control of nursing assessment skills, there should be better consistency in assessments across nursing and medicine.	NC, but progress noted
1	Implement risk assessment and mgmt system = SOC		C
2	Regularly screen for at-risk status		C
3	Compl assmt w/i 5 busn days when new risk ID'd per est criterion		C
4	Develop care plan w/i 30days of assmt; incorporate plan into ISP		C

VII. PSYCHOLOGY			
1	Psychology Director responsible for psych services	The facility has a qualified director of psychology who has provided good leadership with respect to establishing and maintaining quality psychological care.	C
2	Psychology peer review system	The peer review process for BSPs continues to function well.	C
3a	Data protocols will incl info on target/replacement behs-when, where, freq, etc.	A data collection protocol is in place that appears to meet the provision.	C
3b	Monthly rev of data/progress by clinician - modify when no progress	Behavior data is reviewed and progress is characterized monthly. Behavior data review occurs in a variety of contexts (e.g., MIRs, psychiatric consults, BMC Data Reviews). MIR minutes reflect implementation of the Judgment of Progress Protocol and improved interpretation of data trends and action planning. The documentation protocol for psychologists has markedly psychologists' entries to the MIR based on data from July-September 2008, compared to the same period in 2007. In September 2008, according to psychologists' reports, 102 persons showed a lack of expected progress on target behaviors or replacement behaviors. There are frequent references to revisions of BSPs and there generally appears to be a substantive review and consideration of need for revision. There is improved documentation of psychology and the IDT responding to significant events.	C
3c	Protocols for assessing/rectifying data integrity issues	The protocol includes a method for assessing the reliability of data collection.	C
4a	Psychological assmt protocols in place with minimum elements	The facility has standard psychological assessment protocols that address the required areas.	C
4b	other psychological needs that may require intervention, including but not limited to, physical or severe emotional abuse or Post Traumatic Stress Disorder.	Dr. Taylor indicated that the repeat screening for victimization, along with risk for future victimization is continuing.	C

5	Assmts based on current, accurate & complete clinical & beh data	Dr. Taylor is currently doing the peer review on all psychological evaluations. The process appears adequate to meet the provision.	C
6	Complete psych assessment w/i 30 days of admission and annually thereafter	Four out of the five new admissions in the last six months had psychological evaluations within one month of admission. The effort to catch up on overdue updated evaluations continues and reportedly is approximately 40% completed.	NC
7	Psych svcs w/i 30days of being ID'd as needing svcs per above	Data indicate that the provision of individual psychotherapy services has been maintained; participation in group therapy has increased over the past months. 32 individuals are currently receiving individual therapy services; 19 individuals are receiving group therapy services; 3 individuals are receiving mentoring services.	C
8	BSP w/i 30days of assessment & containing minimum components	All required components of the behavior plans are present (maintenance and generalization are addressed in the Functional Assessment report). Program integrity checks document implementation of the BSP.	C
9	BSPs must be able to be understood & implemented by RTWs	BSP reviews include consideration of the readability of the BSP. Data indicate continue progress in improving readability.	C
10	CBT on individualized BSP for staff implementing programs	The system for CBT on BSPs is well-established and serves as a model for CBT in other areas of the facility.	C
11	BSPs revised when needed	The BSPs document revisions introduced into the plan. Psychologists report increased number of revisions to BSPs in the July-September 2008 period, compared to the same period in 2007. BSPs appear to be revised relatively frequently in response to meeting the restraint trigger. Most BSPs (6 of 8 in sample) have documented revisions between required annual revisions.	C
12	Ratios of psychologists (1:30) & pscyh assts (1 asst: 1 psychologist)	All positions are filled and the requisite ratio is met.	C

VIII. MEDICAL			
1	Medical Director responsible for medical services		C
2	Medical peer review system	System not matured as of visit.	NC
3	QA syst incl: clin indicators, trend analysis; corr actions & monitoring	System not matured as of visit.	NC
4	Med error tracking system		C
5	Policies/procedures to ensure med svcs provided consistent with SOC	Policies/procedures not matured as of visit.	NC

X. NURSING			
1	Update Nursing assessment quarterly	Compliance based on review of records of 5 records.	C
2	Nursing diagnoses and care plans updated no less than quarterly	Compliance based on review of records of 5 records.	C
3	Establish nursing protocols for assessment & reporting of medical conditions	Based on review of KQ for whom a 14+ plus hour delay in notification of physician may have prevented timely treatment of a condition that led to his death.	NC, but progress noted
4	Est clinical indicators w/plans of care, incl integrated team dialogue of the same	Needs time to mature.	NC, but progress noted
5	System to monitor/doc progress & modify nsg care plans when needed	Needs time to mature.	NC, but progress noted
6	Procedures for med admin, incl training, supervision, med error tracking	Now included in current nursing policy and procedures.	Pending further review

XI. PHYSICAL & NUTRITIONAL MANAGEMENT			
A. COMMON ELEMENTS			
	Team consisting of RN; PT; OT; RD; SLP; and MD (when needed)	Previously found in compliance with this indicator. There were no previous recommendations. Current Findings: GRC has refined meeting formats and documentation as well as developed a system of peer review. The PNM Core Team included SLP's (4), OTR (1) and RN's (2). Physical therapists (PT) and dietitians (RD), as well as physicians, psychologist/behavior analysts were not dedicated team members but, by report, were available as needed. Follow-up by PT per PT progress note (late entry on 11/18) submitted for UF related to this reviewer's concerns noted during mealtime observation on 11/17/08. However, the PNMP for UF stated that he had "no need for nor does he have a positioning plan", though this was clearly not the case for this young man. This case and additional concerns for positioning for a number of people described below may be the result of inadequate PT involvement in the PNM process. Additionally, errors in diet texture were noted during this review, also calling into question the adequacy of participation by the RD on an "as needed" basis. The philsophy is referred to as "physical and nutritional" management or supports. At Glenwood, representatives in these 2 specialty areas do not participate fulltime in this process. While effective supports may be provided without dedicated team membership, it is significantly more challenging and necessitates a greater need for cross-training and capacity-building for all other clinical staff. Technical Assistance/Recommendation: Continue to critically review the level of participation of non-dedicated clinical staff particularly in the positions of PT and RD, the impact on supports provided and the need for cross-training and collaboration across disciplines.	C

1	Identify persons with PNM issues and causes for PNM issues	Previously found in compliance with this indicator. There were no previous recommendations. Current Findings: PNM/Dysphagia Risk Levels include Critical Care Risk (73 people) for those with high risk assessment scores in the areas of aspiration and pneumonia; High Risk (58 people) for those with designated risk assessment scores or are enterally nourished or with a BMI less than 18.5 in combination with a diagnosis of dysphagia; Moderate Risk (37) with designated choking or pneumonia risk assessment scores; At Risk (82 people) with designated choking or pneumonia risk assessment scores or the presence of GI-related diagnoses; and persons determined to be Not At Risk (69) because they do not present with any of the criteria outlined for another risk level. These designations were consistently identified in the PNMP. Technical Assistance/Recommendations: 1) Carefully track and analyze antecedents for those who experience choking episodes and those considered to be at risk for choking to determine if the "Moderate Risk" or "At Risk" designation consistently affords those people appropriate and adequate review, supports and intervention to prevent such events. (Note: No choking incidents were documented for 2008 to date)	C
2	Implement/maintain mealtime and positioning plans for those identified	GRC previously found to be non-compliant with this indicator. Status of Previous Recommendations: Individual triggers are identified and included in the PNMP. Staff have been trained to respond to individualized or generalized triggers, choking events or coughing with struggle with specific guidelines outlined per policy for ensuring safety, notification, reporting and documentation. Nursing conducts immediate standardized assessments, notifications and implements temporary modifications to PNMP as per policy. In the case that the PNM Leader or Core Team member is not available outside of regular business hours, there is a stand-by PNM staff on call. Incident reports are to be reviewed the next business day and all assessments, updates to risk level and recommendations including PNMP revisions are to be completed by the end of the next business day. Status is reviewed at Core Team meetings until all recommendations are implemented with associated competency-based training (CBT) of staff. Nurses assess lung sounds and oxygen saturation before and after meals for those at critical and high risk levels.	NC

Baselines were established for everyone. Audits related to data completion in the DAR's reported compliance to be at 95% but GRC continues to work to address the reliability of the data reported by staff. GRC has developed Health Data Analysis Training to address issues related to review and application of data obtained but has not yet initiated this. IT supports have been significant in the last 6 months with JSP and PNMP's included in the Electronic Medical Record and as part of the ISP (completion of all JSP's integrated into ISP targeted for January 1, 2009). A system to track CBT has been implemented. There is an electronic action plan system implemented to identify problems, required actions, persons responsible, timeframes for completion and documentation. This system was implemented by the PNM Leader in response to a concern noted by this reviewer related to UF as described below.

Current Findings: Physical Nutritional Management Plans (PNMP) are in place and include person-specific instructions regarding intake, positioning, transfers, medication administration, oral hygiene and adaptive needs for activities of daily living.

PNM Justification and Support Plans (JSP) document risk indicators, outcome measures, triggers with expected staff response, history and status with clinical justification of identified supports and interventions for each person with PNM/Dysphagia Risk as identified via Risk Assessment, Clinical Dysphagia Assessment and other methods. Changes to the PNMP result in associated changes in the JSP.

Positioning is included in the PNMP's described above as well as in alternate positioning plans (APP's). During observations before, during and after mealtimes, XO, EN, UF, HB, CM, MT, EN, QD, KC, WX, among others, were noted to have issues related to appropriate alignment and suppor in wheelchairs or other seating such as dining chairs. Examples included instances of inadequate support for feet and legs, pelvis in posterior tilt or sacral sitting, loose pelvic positioning devices, possible inadequate seat depth, etc. Inadequate alignment and support, at meals and throughout the day, creates risk or at the very least heightens existing risks for people related to dysphagia, aspiration, choking, GI conditions, skin integrity, pneumonia, and other PNM concerns and may negatively impact optimal function and participation in daily activities.

It is not clear, without further assessment, whether the concerns noted by this reviewer resulted from inadequacies of the seating devices, lack of interdisciplinary cross-training and collaboration or were related to ineffective training of direct support staff and/or non-compliance with guidelines for appropriate position, alignment and support.

In the most serious case, UF was seated in his wheelchair with both legs extended, his feet were not supported, his pelvis was in significant posterior tilt, and his pelvic positioning belt was loose. Staff did not attempt to reposition/realign him or encourage him to realign himself prior to his meal. He was rolled up to the table by the staff person at the table pedestal which required that he have it wedged between his extended legs. There was no support for his legs and feet during the meal. His PNMP stated there was "no need for nor does he have a positioning plan" and "n/a" with regard to wheelchair. His PNMP identified him "At Risk" for PNM concerns due to 50% choking risk and 20% pneumonia risk per risk assessments submitted.

His Dysphagia Disorder Survey, dated 1/17/07, stated that his head/neck and trunk were "stable" and that he had no "posture/positioning concerns" per his Choking Risk Assessment, dated 11/19/07. He had a wheeled mobility assessment on 7/17/07 and had received a new seating system. It was documented that UF required staff assistance to ensure that the hip belt was positioned appropriately across his pelvis. Clearly the clinical staff responsible for this young man did not understand the critical need for appropriate position, alignment and support during a meal to ensure safety and optimal independence.

The direct support staff did not have the guidelines and training required to ensure appropriate alignment and support. Compliance monitoring, clinical monitoring and other QA did not identify the ommission in the PNMP for UF. OT interventions were also observed and additional cases of inadequate support during these sessions were noted as with QT and QM.

Recommendations: 1) All clinical staff (OT, PT, SLP at a minimum) would benefit from clinical instruction related to principles of seating and other positioning options, alignment and support and assessment of such to expand the system's capacity to identify and address position and alignment concerns; 2) Audit existing PNMP's and APP's to determine if photographs and written instructions accurately outline the steps required to ensure proper position, alignment and support with correction and retraining as indicated. For example, in the case of UF, there was no indication in his plan that position and alignment should be addressed and no pictures to show how he should be positioned and aligned during meals and/or throughout his day; 3) Review existing system of staff training (foundational and person-specific, as well as that of supervisors and monitors) to determine gaps in communicating the knowledge and skills necessary for implementation of appropriate position and alignment during meals and throughout the day; 4) Incorporate a system of routine position checks and re-positioning particularly prior to meals and activities such as oral hygiene; 5) Conduct QI drills to spot check position and alignment using a coaching model to reinforce training provided.

Additional Current Findings: UF was served ground foods at his meal though "bite size" was indicated on his PNMP. The staff person assisting him did not notice the error. This reviewer brought the error to the attention of Jill Cuff, OTR/L who in turn alerted staff, who had to be directed to make a correction rather than merely acknowledge the error. When a "correction" was made, it was noted by this reviewer that the food had been cut in pieces that were larger than "bite size" and again the staff had to be cued to make the correction. In this case, UF was initially denied a texture that was designated to match his abilities, but then the correction placed him at risk for choking with the large pieces. These errors were further complicated by improper positioning. As the clinical staff did not recognize UF's need for proper alignment, the accuracy of the appropriate diet texture choice for him would also be in question.

Certainly neither the dietary or direct support staff were adequately trained or monitored to ensure accurate implementation of this plan. There was one other instance of the wrong diet texture offered to KS. Again the error was acknowledged when brought to their attention by this reviewer but not corrected (even by the clinical staff present) without prompting. While offering pureed (a lower diet level than that prescribed) to KS might not likely place her at increased risk, she was not provided with the designated texture for her level of ability and independence. Errors of this nature must be considered to be a serious violation and immediately corrected just as the provision of a diet texture higher than that prescribed should be.

While no other errors of this type were noted by this reviewer, not all plans for each person observed were reviewed, but rather were either randomly selected or reviewed when issues related to positioning were noted as in the case of UF above. These errors represent failure at several levels necessitating system review and remediation. Clinical staff and supervisors must be diligent to routinely review food and fluids being presented and insist on and assist with correction as well as to provide appropriate follow-up. Acknowledgement of an error in implementation with failure to ensure correction communicates to staff that it is acceptable to not follow the plan.

Recommendation: All staff (clinicians, monitors, direct support and supervisors, etc.) must be trained to be aware of and accept their responsibility to ensure that the food/fluid offered exactly matches that prescribed in the PNMP. All staff must serve as advocates for the people they support to identify errors made in the kitchen or by the staff plating, serving and presenting the meals, seek immediate and satisfactory correction, document the errors and actions taken and/or report the event per established policy.

3	Ensure staff implement plans, incl positioning before, during & after meals	GRC previously found to be non-compliant with this indicator. Status of Previous Recommendations: GRC conducted round table discussions to determine barriers reagarding reporting of triggers and PNMP implementation. Compliance monitors were formalized with clinical review of data submitted. Action plans are developed for non-compliant or non-effective monitors and by report all actions were completed on time. A system to ensure assessment following hospitalizations is in place for effective communication upon discharge and to implement appropriate supports. There is a head to toe assessment by nursing, updates to risk assessments and other assessments as indicated and resulting in modifications to PNMP supports and CBT as indicated. Current Findings: Guidelines regarding positioning are included in the PNMP's described above as well as in the APP's. During observations before, during and after mealtimes, however, a number of people were noted to have moderate to serious issues related to adequate alignment and support in wheelchairs or other seating such as dining chairs during and outside of mealtimes. In other cases, staff's careful attention to detail related to position and alignment was lacking which suggests insufficient training, monitoring and reinforcement in this area. Compliance with the provision of the correct diet texture was noted in at least 2 instances. In the majority of cases, however, diet orders and other strategies outlined in the PNMP's were noted to be accurately implemented by staff. There is a system of compliance monitoring to review staff execution and implementation of all components on the PNMP. Minimum frequency is for 2 activities during 5/7 days weekly for those at the Critical Care level of risk, though guidelines for compliance monitoring is not outlined for those of other risk levels per the policy submitted, revised 04/01/08. Currrently there is no system designed to "monitor the monitor" to ensure validity and reliability of compliance monitors. Recommendations: 1) Review and revise staff training and competencies to address the following to enhance staff attention to detail: a) Position relates to the person's position in space such as sitting, standing, sidelying, etc.; alignment refers to the way in which body parts are aligned to each other; and support relates to surfaces such as headrests, armrests, footrests, seatbacks and bottoms. These are interrelated but, for example, re-positioning someone does not ensure they are in proper alignment nor does re-alignment ensure adequate support, etc. b) Transfers happen in 3 phases: preparation, the transfer itself and the provision of appropriate support and alignment following the transfer; and c) Reinforcement of the need for re-alignment and checking supports particularly just before meals, oral hygiene and other activities, rather than merely re-positioning "every 2 hours" throughout the day. 2) Implement a system to validate monitors and to ensure reliability of findings.	NC

4	Implement positioning plans for non-ambulatory persons w/PNM issues	GRC previously found to be non-compliant with this indicator. There were no previous recommendations. Current Findings: All persons living at GRC have a PNMP which is updated minimally on an annual basis and at any time there is a change in status or supports/interventions. Per policy, the APP is an extension of that plan in order to provide details related to "repositioning" that cannot be contained within the framework of the PNMP. Per the PNM staff training PowerPoint presentation, the APP is prepared for those with the most complex positioning needs. Policy outlines intended outcomes including optimizing skin integrity, respiratory function, gastrointestinal motility, circulation and to decrease aspiration and pneumonia risk. The policy does not include supporting optimal functional skill performance or participation as a goal. These plans include photographs and written instructions to guide staff implementation. See above for additional analysis of this compliance indicator.	NC
5	CBT for staff implementing plans, both general and individual-specific	GRC previously found to be non-compliant with this indicator. Status of Previous Recommendations: A system has been implemented to ensure that all staff receive CBT prior to working with persons identified at critical or high risk and any person requiring assistance by familiar staff. There is an electronic system to track CBT. Current Findings: A detailed outline of knowledge and skill-based competencies is used related to toothbrushing, positionig, transfers, use of mechanical lift, mealtime adaptive equipment, standard food and fluid presentation strategies, preparing food and liquid consistencies and recognition and response to PNM risk indicators and triggers. By report, recertification of competency is in the second quarter of implementation. As stated above there were concerns regarding staff implementation of generally-accepted principles related to position, alignment and support. In addition, 2 instances of non-compliance with prescribed diet orders as outlined in the PNMP were observed. Effectiveness of staff training and compliance particularly in the area of physical management is of concern. Recommendations: Implement a system to ensure continued competency of staff for implementation of PNMP, including both foundational knowledge and skills as well as person-specific competencies. May include refresher courses, compliance drills, coaching, service recognition and awards, etc.	NC

6	Monitoring of program implementation to ensure appropriateness	GRC previously found to be non-compliant with this indicator. No specific recommendations were previously identified. Current Findings: Monitoring to address appropriateness of PNMP's is conducted via a system of Clinical Monitoring which includes a structured review of the plan, it's success and efficacy, in addition to staff performance with plan implementation. A detailed schedule of frequency of monitoring and types (oral care strategies, positioning strategies, medication strategies and safe swallow strategies) is outlined in the policy according to identified risk level; those at greatest risk are monitored more frequently (99+ total monitorings for those at critical risk, compared to only 6 times per year across each of the 4 areas for those at no risk). According to the schedule identified in the policy submitted, positioning strategies were to be monitored at a minimum of 52 times for those at critical risk, 22 times for those at high risk, 12 times for those at moderate risk, 5 times per year for those at risk (including UF) and 3 times per year for those not considered to be at risk. There are no guidelines regarding timeframes for monitoring session. The current form requires the clinician to document starting time but not end time. There is no method to determine if sufficient time is spent in this activity to accurately assess efficacy of mealtime strategies, for example, that may be impacted by fatigue, distraction, satiation, etc. It was of concern to this reviewer that the area (positioning strategies) receiving the most frequent monitoring by the most clinicians was also the least compliant with generally accepted principles of position, alignment and support per observations of this reviewer and that an omission from the PNMP for UF had gone uncorrected. Recommendations: 1) Consider adding start time/end time data to monitoring documentation; 2) Consider "monitor the monitor" audits for validity and reliability of system.	NC
7	System to monitor individual progress and modify interventions as needed	GRC previously found to be non-compliant with this indicator. Status of Previous Recommendations: These were addressed related to indicators reviewed above. Current Findings: DAR data review with documentation by various IDT members is outlined in policy with scheduled frequency identified. The event log and progress notes permit documentation of pertinent information related to a person's status. PNM Progress notes are written by clinicians to document their actions related to an assessment or identified problem, to document outcomes of a specific contact, change in support or intervention or to document response to referral, action plan or risk event. It was noted during random record review that PNM progress notes did not consistently provide complete information as outlined in the documentation P/P particularly related to justification and inclusion of important details to permit adequate tracking of actions and outcomes. It is critical that clinicians and other team members be able to track a problem through the progress notes to resolution. There should not be a need to track additional documents to put a sequence of events together.	NC

		If additional documents are required the progress note should reference those by name, author and date. In some cases, strategies were recommended or modified for a person without sufficient rationale. Such omissions make it difficult at best or impossible at times to track problems through to resolution, validate efficacy of interventions or communicate critical actions to other team members. It was also noted in one submission that of of 28 entries since 1/22/07, 15 were listed as "late entry", one as late as 13 days; others ranged from 1 day to 1 week. Contact notes should be completed within no more than 24 hours to ensure that information is available to all IDT members for utilization. There are no guidelines per policy as to timeframes for completion of progress/contact notes. There is also no written guideline regarding timeframes for updates of JSP to reflect changes in interventions and supports. The Action Plan system is utilized to assign responsibility for specific actions in response to a referral, incident or in relation to a change in status or new finding. A "To Do" list is created for each clinician and a current version is available to them in the IPR. Documentation is completed electronically via follow-up notes and the plan can be updated as actions are completed. Monthly Integrated Review notes are provided by PNM staff prior to the MIR meeting to provide an update of all events and actions during that month. Recommendation: 1) Develop guiding questions to ensure thoroughness of all documentation by clinical staff particularly for PNM progress notes and MIR documentation.	
8	Eval medical necessity for g-tubes; return to oral feeding when appropriate	GRC previously found to be non-compliant with this indicator. Status of Previous Recommendations: A protocol for Therapeutic and Pleasure Eating was developed on 9/22/08 and is currently implemented. A specific policy related to medical necessity of enteral tube use was not submitted for review. However PNM risk levels are reviewed and/or reassessed monthly as an aspect of the MIR process and with each occurrence of incident or change in status. All persons receiving enteral nutrition are considered to be at least to the high risk level with increased monitoring provided by clincians. While review of medical necessity of continued enteral tube use may be implied, there did not appear to be specific guidelines for the IDT to specifically address the continued appropriateness of enteral nutrition for each person who receives it.	NC

B. PHYSICAL AND OCCUPATIONAL THERAPY			
1	Screening/comprehensive assessments will incl minimum elements	Previously found in compliance in this area. Current Findings: OT and PT assessments reviewed appeared thorough but did not adequately address the concept of improved function or skill acquisition as an expected outcome of therapeutic intervention, which is an established standard of practice. Goals were generally related to maintenance or activities such as range of motion without functional outcome expectations as a result of improved range of movement. In these cases, range of motion must be measured as well as progress toward the expected outcome. In some cases, there was insufficient justification for continued range of motion interventions as recommended. For example, there was no justification as to how increased ROM would impact HB's quality of life or function, particularly given that during the previous year, despite PT intervention, no changes in ROM or function had been documented. The assessment described current status but did not present a comparative analysis with the previous year. In the case of EL, her PT assessment stated that she had received interventions for balance and ambulation. There were no goals or outcomes described for the interventions provided during the year and descriptions of progress or changes as a result of those interventions were absent. The PT completing the assessment described balance in sitting but relied on "reports" to describe balance in standing despite the provision of PT interventions to address balance over the course of the last year. Continued PT intervention was again recommended for balance and ambulation without sufficient evidence of efficacy of such a program for DK. In the case of LC, PT intervention was prescribed to address heel cord tightness and higher-level balance skills. There were no specific goals or description of progress related to heelcord ROM or balance skills. In fact, it was stated in the assessment that her static and dynamic balance was sufficient for ADL's without a device or physical assistance. There was no evidence presented to justify the need for continued therapeutic intervention for functional change in skill, participation or quality of life. This issue is not being identified via the current peer review process.	C

2	Plans w/indiv interventions/outcomes/adapt equip & plan to minimize regression	Previously found in compliance in this area. During observation of OT interventions during this on-site review, it was noted that interventions were isolated and did not relate to measurable outcomes impacting quality of life or opportunities for skill acquisition. Strategies used need further refinement to address this issue. Unfortunately indicator states "minimize regression". This is not an acceptable outcome of therapeutic supports in the ICF setting. There should be an expectation of change with measureable objectives for both direct therapy provided by licensed clinicians as well as that provided by therapy technicians or aides who have been trained to competency to implement programs designed and reviewed by licensed professional staff in addition to skill/status maintenance activities for some residents.	C
3	CBT for staff implementing plans, both general and individual-specific	Previously found in compliance in this area. Based on this reviewer's observations and review of documents, OT and PT interventions would benefit from review of purpose and strategies for reliability and efficacy by the program authors/clinicians, to include CBT for therapy support staff related to changes and to ensure reliablity of implementation and validity of documentation.	C
4	QA system to monitor individual status; equip avail/cond & TX efficacy	Previously found in compliance in this area. Current Findings: Comparative analysis of status or statement of progress are absent from therapy assessments and has not been addressed through the current QA or peer review systems.	C

XII. COMMUNICATION			
1	SLP competent in augment/alter comm; assmts; prog dev/impl/monitoring & CBT	SLP staff includes individuals with training and experience in augmentative and alternative communication. Additional SLP staff have been hired and recruitment for a director for the SLP department is underway. Reorganization of the SLP department is underway, and will devote four SLPs to the communication portion of the mission. These changes appear promising; however, their impact cannot yet be evaluated.	NC
2	System to ID persons needing augment/alternative communication devices	The facility has implemented a monthly Alternative / Augmentative Communication Clinic to evaluate individuals referred by the teams for possible implementation of AAC programs. 23 individuals have been seen in this clinic to date, 16 of whom were recommended for an AAC program. This is a recent development; the monthly clinics will continue as long as there is a need. The above developments are not reflected in the Speech/Language Screening & Evaluations (11/06) document; revision of this document is needed to ensure that the procedures are institutionalized and continue to provide the needed screening and assessment.	C

3	Implement functional/adaptable comm plans for persons above; rev annually	Communication training continues to be a serious deficit at the facility. Communication "plans" provided for review during this tour continue to be only communication matrices and did not include any reference to training programs intended to develop appropriate communication behaviors. A recently hired SLP is using an inventory of communication opportunities as an additional assessment to support development of programs for expressing choice; there is interest in using an inventory of communication skills to assist in measuring progress but this is not yet implemented. This SLP has provided leadership in identifying a conceptual model for the communication training programs. She has begun implementing the model in four houses. The model leads to the development of an individualized communication intervention plan. An example of programs initiated under this model appeared promising. The facility plans to provide training to staff on the model and implications for treatment and training by the end of December 2008. The facility's commitment to this model is not reflected in the Procedures for Communication Intervention (3/29/05). This document requires revision to incorporate the principles and practices of the proposed model. The document Communication Plans (9-5-06) appears to be significantly out of date and does not reflect recent developments with respect to communication assessment and communication plan development. It requires revision. It will be important to revise these documents to capture the changes that are underway in order to ensure that they are maintained.	NC

XIII. HABILITATION			
1	Ann assmts/qrtly rev of indiv strengths/pref/skills/needs/ barriers to comm liv	Assessment in these areas has been improved and appears to be generally adequate.	C
2a-e	Develop training/education/skill acquisition progs from above & incl min elements	Habilitation training programs continue to improve. A protocol is in place for writing goals and objectives. Programs generally specify strategies and supports adequately. Interventions are generally practical and functional and there are reasonable efforts to include training in community settings.	C
2f	Programs have explicit data reqs, incl what data, freq, who collects & who reviews	The required components are included in the Individual Habilitation Plans	C

3	CBT for staff implementing plans, both general and individual-specific	Staff are trained on individuals' ISPs which include information about habilitation training programs; however, the training does not include assessment of knowledge of training program details, nor ability to carry the programs. The facility has produced an Individual Implementation Plan Implementation Integrity Check Protocol which appears to be adequate. There exists one month's data regarding integrity checks but the system is so recently implemented that there are no summaries, analyses, or interpretations of the Integrity Check data. The approach that the facility has taken is to implement integrity checks first and allow those data to dictate the details of competency-based training. It is anticipated that the data will lead to more specific and more intensive competency-based training for habilitation programs.	NC
4	Monthly rev by IDT member on progress/status/prog efficacy, revising as needed	The facility has adopted a Judgment of Progress protocol that establishes indicators of a need for program review / revision. The protocol appears to be adequate and should support However, the protocol is not yet being consistently implemented during MIRs with respect to habilitation programs.	NC
5	Ensure Habilitation QA process in place	The peer review for ISPs appears to be an adequate quality assurance process to meet this requirement.	C