

**REPORT 10**

**METROPOLITAN STATE HOSPITAL**

**March 7-11, 2011**

**THE HUMAN POTENTIAL CONSULTING GROUP  
ALEXANDRIA, VIRGINIA**

## NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Metropolitan State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Metropolitan State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Metropolitan State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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**Acronyms used in Court Monitor reports:**

AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
ACLS	Advanced cardiac life support
ACNS	Assistant Coordinator of Nursing Services
ACT	Administrative Clinical Team
AD	Administrative Directive
ADCAP	Audit-Driven Corrective Action Plan
ADR	Adverse drug reaction
AED	Anti-epilepsy drug
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
A/N/E	Abuse/Neglect/Exploitation
ARNP, BC	Advanced Registered Nurse Practitioner, Board Certified
ART	Assault Reduction Taskforce
ASH	Atascadero State Hospital
ASI	Addiction Severity Index
ASL	American Sign Language
A-WRP	Admission Wellness and Recovery Plan
B & B	Bladder and Bowel
BCC	Behavioral Consultation Committee
BFA	Basic First Aid
BG	Behavior Guidelines
BMI	Body Mass Index
CA	Clinical Administrator
CAC	Cooperative Advisory Council
CAF	Corrective Action Form
CASAS	Comprehensive Adult Student Assessment Systems
CCA	Clinical Chart Auditing
CDC	Centers for Disease Control and Prevention

CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
CMT	Clinical Management Team
CON	Clinical Oversight Nurse
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment/Court-Ordered Outpatient Treatment
COVR	Classification of Violence Risk
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CSW	Clinical Social Worker
CV	Curriculum vitae (i.e. resumé)
CVA	Cerebrovascular accident
CXR	Chest x-ray
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice
DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTO	Danger(ousness) to others
DTR	Dietetic Technician, Registered
DTS	Danger(ousness) to self
DUE	Drug Utilization Evaluation
Dx	Diagnosis

EAP	Employee Assistance Program
ED	Executive Director
EKG	Electrocardiogram
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
FDA	Food and Drug Administration
FMLA	Family and Medical Leave Act
FPA	Focused Psychological Assessment
FQRP	Forensic Quality Review Panel
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
FTS	Follow Through Staff
F/U	Follow up
GAF	Global Assessment of Functioning [Score]
GIVI	Gastrointestinal viral illness
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HEP	High Efficiency Particulate Air
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HOM	Hospital Oversight and Monitoring
HSS	Health Services Specialist

HTN	Hypertension
Hx	History
IAPS	Integration Assessment: Psychology Section
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
ICLN	Infection Control Liaison Nurse
ICPT	Infection Control Psych(iatric) Tech(nician)
IDN	Inter-Disciplinary Note
IER	Independent External Review
IMRC	Incident Management Review Committee
INPOP	Individualized Nursing Physical/Occupational Plan
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology
LPS	Lanterman-Petris-Short [Act] (re involuntary civil commitment)
LTBI	Latent tuberculosis infection
LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MAR	Medication Administration Record
MAS	Medical Ancillary Services
MBS	Modified barium swallow
MDO	Mentally Disordered Offender
MFT	Marriage and Family Therapist
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MOSES	Monitoring of Side Effects Scale
MPPN	Monthly Physician's Progress Note
MRMC	Medical Risk Management Committee

MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous; Nurse Administrator
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCA	Nutrition Care Assessment
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
NFA	Neuropsychological Focused Assessment
NGA	New generation antipsychotic
NGRI	Not guilty by reason of insanity
NMS	Neuroleptic Malignant Syndrome
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy; Nurse Practitioner
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
ORIF	Open Reduction with Internal Fixation [procedure to set bones]
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
P&P	Policy and Procedure/Policies and Procedures
P&T	Pharmacy and Therapeutics [Committee]
PAC	Psychopharmacology Advisory Committee
PBS	Positive Behavior Support

PC	Penal Code
PCP	Primary Care Physician
PFA	Psychology Focused Assessment
PHN	Public health nurse
PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
PNED	Psychiatric Nurse Education Director
POC	Plan of Correction
POS	Physician Order System
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRC	Program Review Committee
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	Physical Therapy/Therapist (in Sections D.4 and F.4); Psychiatric Technician (in Sections D.3 and F.3)
PWT	Program-Wide Trainer
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RCA	Root Cause Analysis
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RM	Risk management
RMS	Record Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant

R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SE	Sentinel Event
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation; special investigation/investigator; self-injury
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SOAP	Subjective, Objective, Assessment, Plan
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SR	Substance Recovery
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRS	Substance Recovery Services
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
STA	Secure Treatment Area
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions

TST	Tuberculin skin test
Tx	Treatment
URN	Utilization Review Nurse
VRA	Violence Risk Assessment
VRAT	Vocational Rehabilitation Assessment Tool
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition
WaRMSS	Wellness and Recovery Model Support System
WNL	Within Normal Limits
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

## Introduction

### A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Metropolitan State Hospital (MSH) from March 7-11, 2011 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C.1, C.2, D.1 through D.7, E, F.1 through F.9, G, H, I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve and maintain compliance. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations are directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

## **B. Methodology**

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and the facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative and clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

The Court Monitor's compliance findings are a function of independent review and judgment, taking into consideration both quantitative and qualitative factors related to the requirements of the particular EP cell.

The Monitor's quantitative data is typically collected through chart reviews while on site. Sources of qualitative information include: a) chart reviews; b) staff interviews; c) observations of teams, programs and the environment of care; d) assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance; and e) assessment of trends and patterns of change rather than single and/or temporary occurrences that are inconsistent with these patterns and trends. The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

The Monitor may also evaluate his findings relative to data presented by the facility that result from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

In the ratings of compliance, the Monitor uses a scale of non-compliance, partial compliance and substantial compliance. A rating of non-compliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the Court Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of substantial

compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

**C. Statistical Reporting**

The following statistical abbreviations used in the report are defined as follows:

<b>Abbreviation</b>	<b>Definition</b>
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

**D. Findings**

This section addresses the following specific areas and processes, some of which are not covered in the body of the compliance report.

1. Key Indicator Data

Key indicators are tracked by each facility as a management tool that can provide an overview of system performance across a number of domains. The key indicators can serve as a "dashboard" for facility leadership in terms of summarizing general performance and assessing trends, but they cannot stand alone as a means of formulating judgment regarding facility performance and practices, including such judgments that are part of EP monitoring. The court monitor reviews the key indicators from a statistical point of view, taking into consideration relative clinical significance, but does not conduct independent validation of the data. At times the court monitor will comment upon changes that he believes require the facility's attention, but the absence of comment by the court monitor should not be construed as an indication that no attention, investigation or follow-up is necessary. Facility management should continuously review the key indicators to assess trends and patterns and use this data to identify the factors that contribute to changes in facility trends and patterns. Taken as a whole, the key indicators presented by MSH at the time of this review indicate stable performance in a number of domains over the past six months.

## 2. Monitoring, mentoring and self-evaluation

a. Regarding the process of self-assessment, this monitor has requested the following:

i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:

- Comparison of the mean compliance rates for the main indicator in the entire review period from the current to the previous periods;
- Comparison of the mean compliance rates for the main indicators and sub-indicators (if they were presented) from the last month of the current review period to the last month of the previous review period;
- A review of the facility's assessment of barriers towards compliance; and
- A plan of correction.

ii. For data demonstrating compliance rates of 90% or more with the main indicators, all facilities should provide comparison of mean compliance rates with the main indicators for the entire review period from the current to the previous periods.

iii. For data derived from the DMH standardized auditing tools, all facilities should present their data using the same configuration of indicators/sub-indicators for each corresponding requirement of the EP.

MSH presented its self-assessment data and data comparisons in the format requested above.

b. MSH has utilized all available DMH standardized auditing tools for all applicable sections of the EP. At this juncture, the Court Monitor will accept reduction of the facility's sample sizes if DMH decides that this can be accomplished without compromising the facility's oversight function.

c. In general, the facility has maintained progress in self-monitoring processes. However, in the area of substance use services, the facility continued to have difficulty in presenting a data set that was internally consistent despite findings to this effect by this monitor during the previous review.

d. As mentioned repeatedly in earlier reports by this monitor, all facilities must ensure that discipline chiefs and senior executives review the monitoring data (including key indicators) on a monthly basis and use the results of these reviews to enhance service delivery within each facility. The monitoring (including key indicator) data across hospitals should be reviewed quarterly by the DMH so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

## 3. Implementation of the EP

a. In general, MSH has maintained progress in its disciplinary services with the notable exception of substance use services.

b. It is important to repeat that ultimate success in this process must include, at a minimum, compliance with the requirements that are essential to the safety and well-being of the individuals in care. The monitor is aware that incidents, including serious

incidents, can happen in any facility, particularly in facilities that care for individuals who are seriously mentally ill and also have histories of involvement with the criminal justice system, and that certain adverse events can be at least partially explained by factors outside the facility's control independent of clinical performance. However, all facilities are expected to have effective Risk and Quality Management and administrative oversight systems that ensure proper and timely identification of high-risk situations, remedial actions without delay, continuous and critical assessment of patterns and trends of these situations and development and implementation of data-based corrective actions and of systems to monitor the appropriateness and efficacy of these actions.

- c. MSH has maintained progress in its risk management procedures regarding the care of individuals who met a variety of high-risk triggers and thresholds (in civil and forensic units). In general, the facility's WRPTs and practitioners have implemented timely and appropriate reviews of high-risk situations and developed and provided adequate and timely clinical interventions to reduce the risk. The Program, Enhanced Trigger and Facility Review committees have, in general, conducted adequate reviews and recommendations to ensure progressive levels of interventions commensurate with the levels of risks.
- d. The facility's Aggression Reduction Committee has conducted adequate analysis of aggression incidents and aggregated data based on a review of various variables and other factors contributing to aggression and the analysis was reviewed by the facility's Quality Council. In preparation for this tour, the committee expanded and modified its review and analysis of factors contributing to aggression. The revised analysis was thorough and comprehensive but it has yet to be reviewed by the facility's Quality Council. Based on this work, the committee developed a wide range of adequate and comprehensive administrative and clinical corrective actions, some of which were implemented and others are in either process or being planned. Further details are reviewed in Section I, Performance Improvement.
- e. During the previous review, this monitor cautioned the facility that inadequate senior administrative oversight of the mortality reviews contributed to an environment in which individuals' safety and well-being were seriously compromised. This finding was reiterated in both the introduction and the body of Report 9. Thus it was problematic to find that during this review period, the facility's chief executive did not attend any mortality reviews or provide necessary administrative follow-up. The risks are heightened in situations that require the oversight and coordination of interdisciplinary interventions, such as in one of the unexpected mortalities and one sentinel event that occurred during this review period. The facility and DMH must rectify this situation in a timely manner.
- f. DMH has developed and initiated implementation of streamlined templates for the documentation of WRPs and disciplinary assessments and reassessments with input from its clinical staff. If properly implemented, these templates can optimize an adequate balance in practitioners' time between direct care and documentation while meeting requirements of the EP. DMH should continue its efforts to ensure full implementation of these templates.
- g. MSH has continued its progress in the psychosocial rehabilitation of its individuals as specified in relevant sections in this report. As mentioned previously, all four facilities have achieved a system of assessment and care of individuals with cognitive impairments that is a model for the public mental health system nationwide.

- h. MSH has maintained progress in ensuring that providers of Mall groups complete the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs and that the information is consistently filed in the charts. However, further progress is needed to ensure that Mall facilitators address in their progress notes the individual's status on the objectives to be addressed per the WRP.
- i. Those facilities that care for individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions.
- j. DMH should continue its efforts to standardize across all hospitals the Administrative Directives that guide clinical services.

4. Staffing

The table below shows the current staffing pattern at MSH:

<b>Metropolitan State Hospital Vacancy Totals as of January 31, 2011</b>				
<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
<b>Nursing Classifications</b>				
Hospital Worker	3.00	3.00	0.00	0%
Licensed Vocational Nurse	34.00	32.00	2.00	6%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT*	303.21	277.00	26.21	9%
Sr. Psychiatric Technician	36.00	31.00	5.00	14%
Registered Nurse*	157.70	145.00	12.70	8%
Supervising Registered Nurse	9.00	5.00	4.00	44%
Unit Supervisor	19.00	17.00	2.00	11%
Nurse Practitioner	1.00	1.00	0.00	0%
<b>LOC Professionals</b>				
Physician & Surgeon	19.20	16.00	3.20	17%
Psychologist-HF, (Safety)	35.90	35.00	0.90	3%

**Metropolitan State Hospital Vacancy Totals as of January 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Rehabilitation Therapist	37.27	38.60	-1.33	-4%
Clinical Social Worker	39.89	35.00	4.89	12%
Sr. Psychiatrist	11.13	7.00	4.13	37%
Sr. Psychologist (Spvr and Spec)	9.00	6.00	3.00	33%
Staff Psychiatrist	39.07	37.50	1.57	4%
Supervising Psychiatric Social Worker	2.00	2.00	0.00	0%
Supervising Rehabilitation Therapist	4.00	4.00	0.00	0%
<b>Other</b>				
Assistant Coordinator of Nursing Services	5.0	4.0	1.0	20%
Assistant Director of Dietetics	4.0	4.0	0.0	0%
Audiologist	0.0	0.0	0.0	0%
Chief Dentist	1.0	1.0	0.0	0%
Chief, Central Program Services	1.0	1.0	0.0	0%
Chief Physician & Surgeon	1.0	1.0	0.0	0%
Chief Psychologist	1.0	1.0	0.0	0%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	8.0	6.5	1.5	19%
Clinical Laboratory Technologist	4.0	4.0	0.0	0%
Coordinator of Nursing Services	1.0	0.0	1.0	100%
Coordinator of Volunteer Services	1.0	1.0	0.0	0%
Dental Assistant	2.0	1.0	1.0	50%
Dentist	1.0	1.0	0.0	0%
Dietetic Technician	2.0	2.0	0.0	0%
E.E.G. Technician	1.0	1.0	0.0	0%

**Metropolitan State Hospital Vacancy Totals as of January 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Food Service Technician I and II	72.0	68.0	4.0	6%
Hospital Police Lieutenant	2.0	2.0	0.0	0%
Hospital Police Sergeant	6.0	6.0	0.0	0%
Hospital Police Officer	52.0	46.0	6.0	12%
Health Record Technician I	25.0	22.0	3.0	12%
Health Record Techn II Sp	6.0	5.0	1.0	17%
Health Record Techn II Sup	3.0	2.0	1.0	33%
Health Record Techn III	2.0	2.0	0.0	0%
Health Services Specialist	36.0	32.0	4.0	11%
Institution Artist Facilitator	1.0	0.8	0.2	20%
Medical Technical Assistant	0.0	0.0	0.0	0%
Medical Transcriber	5.0	3.0	2.0	40%
Medical Transcriber Sup	0.0	0.0	0.0	0%
Sr Medical Transcriber	1.0	1.0	0.0	0%
Nurse Instructor	4.0	4.0	0.0	0%
Nursing Coordinator	8.0	7.0	1.0	13%
Office Technician	41.0	37.0	4.0	10%
Pathologist	0.0	0.0	0.0	0%
Pharmacist I	17.6	14.6	3.0	17%
Pharmacist II	2.0	2.0	0.0	0%
Pharmacy Services Manager	1.0	1.0	0.0	0%
Pharmacy Technician	13.6	11.0	2.6	19%
Podiatrist	1.0	1.0	0.0	0%
Pre-licensed Pharmacist	0.0	0.0	0.0	0%

**Metropolitan State Hospital Vacancy Totals as of January 31, 2011**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Program Assistant	7.0	6.0	1.0	14%
Program Consultant (RT, PSW)	2.0	0.0	2.0	100%
Program Director	6.0	5.0	1.0	17%
Psychiatric Nursing Education Director	1.0	1.0	0.0	0%
Psychiatric Technician Instructor	1.0	1.0	0.0	0%
Public Health Nurse II/I	2.0	2.0	0.0	0%
Radiologic Technologist	1.0	1.0	0.0	0%
Special Investigator	1.0	1.0	0.0	0%
Special Investigator, Senior	3.0	3.0	0.0	0%
Speech Pathologist I	0.0	0.0	0.0	0%
Sr. Radiologic Technologist (Specialist)	1.0	1.0	0.0	0%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.0	0.0	0.0	0%
Teacher-Adult Educ./Vocational Instructor	6.0	6.0	0.0	0%
Teaching Assistant	0.0	0.0	0.0	0%
Vocational Services Instructor	2.0	2.0	0.0	0%

*\* Plus 22.5 hourly intermittent PT, PLPT, PTA and PTT FTEs*

*\*\* Plus 10.17 hourly intermittent Registered Nurse FTEs*

Key vacancies at this time include senior psychiatric technicians, RNs, senior psychiatrists and senior psychologists.

**E. Monitor's Evaluation of Compliance**

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;

3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future; and
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. If any hospital maintains substantial or full compliance with any section of the EP for 18 months (four consecutive tours), the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to provide needed oversight.

#### **F. Next Steps**

1. The Court Monitor's team is scheduled to reevaluate Metropolitan State Hospital from August 29 to September 2, 2011.
2. The Court Monitor's team is scheduled to tour Atascadero State Hospital from April 18-22, 2011 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

<p><b>C. Integrated Therapeutic and Rehabilitation Services Planning</b></p>	
<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. MSH has achieved substantial compliance with all of the requirements of Section C.1.</li> <li>2. MSH has maintained a WRP training and mentoring program that is sufficient to meet its needs.</li> <li>3. MSH has maintained progress in addressing the needs of individuals with seizure and cognitive disorders.</li> <li>4. MSH has continued to make progress in the organization and implementation of the Supplemental Activities.</li> </ol> <p><b>Areas of Need Include:</b></p> <ol style="list-style-type: none"> <li>1. <i>The facility has yet to strengthen its oversight of substance use services to ensure proper alignment of the individual's stages of change and WRP objectives and interventions and accuracy of process and clinical outcome data using consistent indicators and methodology.</i></li> <li>2. <i>Ensure that WRPTs continue to receive training on identifying and documenting individuals' strengths to enable Mall group and therapy service providers to utilize the strengths in their work with the individuals.</i></li> <li>3. <i>Increase participation of disciplines in Mall group provision.</i></li> <li>4. <i>Ensure that inconsistencies in Mall progress notes are resolved and that Mall facilitators address in their progress notes the individual's status on the objectives to be addressed as documented in the objective sections of the individual's WRP.</i></li> <li>5. <i>Ensure that Mall group auditors document information from their observations in addition to checking the "Yes" and "No" boxes, for example the types of instructional techniques utilized, the level of language used, the level of language found in the handouts, etc., in order to more comprehensively evaluate</i></li> </ol>

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		<p><i>facilitation practice.</i></p> <ol style="list-style-type: none"><li><i>6. Fix WaRMSS module dealing with Clinic Appointment, collect and present data on appointment kept and cancelled. Develop and implement interventions for low compliance.</i></li><li><i>7. Collect, analyze, and present non-adherence data, and show interventions utilized to address low compliance.</i></li></ol>
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1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ashvind Singh, PhD, Treatment Enhancement Coordinator (TEC)</li> <li>2. Michael Barsom, MD, Medical Director</li> <li>3. Nady Hanna, MD, Assistant Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. DMH Clinical Chart Auditing Form summary data (August - January 2010/2011)</li> <li>2. DMH WRP Observation Monitoring summary data (August - January 2010/2011)</li> <li>3. DMH WRP Team Facilitator Observation Monitoring Form summary data (August - January 2010/2011)</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program II, unit 412) for monthly review of MCL</li> <li>2. WRPC (Program II, unit 414) for monthly review of SH</li> <li>3. WRPC (Program II, unit 416) for annual review of VS</li> <li>4. WRPC (Program II, unit 416) for monthly review of WMV</li> <li>5. WRPC (Program III, unit 401) for monthly review of MG</li> <li>6. WRPC (Program III, unit 401) for quarterly review of JH</li> <li>7. WRPC (Program III, unit 409) for annual review of JMT</li> <li>8. WRPC (Program III, unit 415) for quarterly review of GG</li> <li>9. WRPC (Program V, unit 403) for quarterly review of CKA</li> <li>10. WRPC (Program VI, unit 419) for annual review of SB</li> <li>11. WRPC (Program VI, unit 419) for monthly review of AB</li> <li>12. WRPC (Program VI, unit 419) for monthly review of GCB</li> </ol>
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the	<b>Current findings on previous recommendations:</b>

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	<p>individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.</p>	<p><b>Recommendation 1, September 2010:</b>          Correct the [deficiencies noted in this cell in the previous report] in the WRPC process and ensure that WRPTs clearly get the message that the WRP process is a dynamic undertaking that should always be tailored to the individual's current status. This should be considered in the current DMH efforts to streamline the WRP content.</p> <p><b>Findings:</b>          During this review period, MSH reported the following actions:</p> <ol style="list-style-type: none"> <li>1. Department Chiefs and Senior Clinicians conducted training of staff in their disciplines on both group and one-to-one as-needed bases (see recommendation 2 below).</li> <li>2. Department Chiefs utilized monthly meetings to reinforce WRP and Recovery concepts and WRPT functioning.</li> <li>3. One-to-one mentoring was provided for those staff who had either requested additional support and/or for those staff who were identified by observation and/or audit data as requiring individualized support.</li> <li>4. During the WRP content streamlining process, the facility focused on clinical outcomes, improved communication with the individual, and making the WRP and review more meaningful for the individual.</li> </ol> <p><b>Recommendations 2 and 3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide an update of WRP training and mentoring activities during the reporting period.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b>          The following is a summary of the facility's WRP training and mentoring activities during this review period:</p> <ol style="list-style-type: none"> <li>1. All new employees and existing WRP members who required</li> </ol>
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		<p>attendance received the WRP comprehensive training class. Training occurred monthly with the exception of September 2010. From August 2010 to January 2011, 84 WRPT members attended the comprehensive WRP training. This represents 100% compliance for new employees. Competency was determined through the use of the WRP knowledge assessment. All WRPT members scored 90% or higher in a competency examination.</p> <ol style="list-style-type: none"> <li>2. Recovery training was offered monthly and attended by a total of 666 employees, both new and enduring (765 staff were expected to attend recovery training, for an attendance ratio of 87%). This training was specific to the history and development of the Psychosocial Recovery model, the necessity and desirability of change, and the positive outcomes in the application of Recovery concepts. All WRPT members scored 90% or higher in a competency examination.</li> <li>3. Department Chiefs and Senior's conducted training of staff in their disciplines during this review period. Training was provided in the core disciplines: psychiatry, psychology, social work, rehabilitation and nursing (RNs and psychiatric technicians). Training was provided on a one-to-one as-needed basis for those staff who had either requested additional support and/or for those staff who were identified by audit as requiring individualized support. Competency continues to be ensured by audit, mentoring, and ability of staff to verbalize understanding. During this review period, MSH incorporated WRP mentoring and computer training into the discipline-specific training.</li> <li>4. By Choice training continued from the last review period and was offered monthly. The training was attended by 359 employees, both new and enduring (504 nursing staff were expected to attend training for a 71% attendance rate). The focus of the class was to introduce and reinforce techniques for providing and maintaining the incentive program and providing support for individuals. All WRPT members scored 90% or higher in a competency examination.</li> </ol>
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		<p>5. Personal Safety and Security training was initiated during this review period for support staff (Plant Operations/Housekeeping/Dietary) in four separate sessions on January 20, 2011. The focus of the training was to educate staff on personal safety, offer sound techniques and strategies for safety, and emphasize awareness. This training was attended by 153 staff and expected 200 for an attendance rate of 77%. Competency was ensured by verbal feedback from participants in a question-and-answer format.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month (August 2010 - January 2011):</p> <table border="1" data-bbox="976 670 1875 1008"> <tr> <td data-bbox="976 670 1073 821">1.</td> <td data-bbox="1073 670 1780 821"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1780 670 1875 821">94%</td> </tr> <tr> <td data-bbox="976 821 1073 1008">2.</td> <td data-bbox="1073 821 1780 1008"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1780 821 1875 1008">98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p><b>Other findings:</b> The monitor and his experts attended 12 WRPCs. The meetings demonstrated that in general, MSH has maintained substantial compliance with the requirements regarding the WRP process.</p> <p><b>Compliance:</b> Substantial.</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	94%	2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	98%
1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	94%						
2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	98%						

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period.</li> <li>2. Continue to monitor this requirement.</li> <li>3. Accelerate efforts to streamline the process (and content) of WRP review with input from practitioners.</li> </ol>												
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 1, September 2010:</b> Same as in Recommendations 1 and 3 in C.1.a.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 100% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 52% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="976 1154 1877 1416"> <tr> <td data-bbox="976 1154 1073 1192">1.</td> <td data-bbox="1073 1154 1782 1192"><i>The team psychiatrist was present.</i></td> <td data-bbox="1782 1154 1877 1192">100%</td> </tr> <tr> <td data-bbox="976 1192 1073 1268">2.</td> <td data-bbox="1073 1192 1782 1268"><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td data-bbox="1782 1192 1877 1268">100%</td> </tr> <tr> <td data-bbox="976 1268 1073 1385">3.</td> <td data-bbox="1073 1268 1782 1385"><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td data-bbox="1782 1268 1877 1385">100%</td> </tr> <tr> <td data-bbox="976 1385 1073 1416">4.</td> <td data-bbox="1073 1385 1782 1416"><i>The team facilitator ensured that the interventions</i></td> <td data-bbox="1782 1385 1877 1416">100%</td> </tr> </table>	1.	<i>The team psychiatrist was present.</i>	100%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%	4.	<i>The team facilitator ensured that the interventions</i>	100%
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4.	<i>The team facilitator ensured that the interventions</i>	100%												

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		<p style="text-align: center;"><i>were linked to the objectives.</i></p> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.c	Function in an interdisciplinary fashion.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 97% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and	<p><b>Current findings on previous recommendation:</b></p>

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	<p>appropriate psychiatric and medical care.</p>	<p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Audit, MSH reported a compliance rate of 94% based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010 - January 2011). Comparative data showed that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.1.e</p>	<p>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as Recommendations 1 and 3 in C.1.a.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 94% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 95% for the review period, based on a 20% sample of quarterly and annual WRPs due in the review months. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (August 2010 - January 2011):</p>

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		<p>5. <i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></p>	<p>100%</p>																					
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																						
<p>C.1.h</p>	<p>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue efforts to increase attendance of all WRPT members at WRPCs.</p> <p><b>Findings:</b> MSH presented core WRPT member attendance data based on an average sample of 20% of quarterly and annual WRPCs held during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="976 1118 1740 1424"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>85%</td> <td>83%</td> </tr> <tr> <td>Psychiatrist</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Psychologist</td> <td>83%</td> <td>92%</td> </tr> <tr> <td>Social Worker</td> <td>91%</td> <td>90%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>91%</td> <td>92%</td> </tr> <tr> <td>Registered Nurse</td> <td>99%</td> <td>100%</td> </tr> </tbody> </table>			Previous review period	Current review period	Individual	85%	83%	Psychiatrist	100%	100%	Psychologist	83%	92%	Social Worker	91%	90%	Rehabilitation Therapist	91%	92%	Registered Nurse	99%	100%
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Rehabilitation Therapist	91%	92%																						
Registered Nurse	99%	100%																						

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		Psychiatric Technician	91%	94%	<p>The data showed indicated that the facility has improved attendance by psychologists in the WRPCs since the last review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																				
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="976 898 1663 1393"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>PTs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td colspan="3" style="text-align: center;">Long-Term Units</td> </tr> <tr> <td>MDs</td> <td>1:23</td> <td>1:25</td> </tr> <tr> <td>PhDs</td> <td>1:23</td> <td>1:23</td> </tr> <tr> <td>SWs</td> <td>1:22</td> <td>1:23</td> </tr> </tbody> </table>					Previous review period	Current review period	Admission Units			MDs	1:15	1:15	PhDs	1:15	1:15	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:15	1:15	PTs	1:15	1:15	Long-Term Units			MDs	1:23	1:25	PhDs	1:23	1:23	SWs	1:22	1:23
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RTs	1:24	1:25										
RNs	1:23	1:25										
PTs	1:22	1:25										
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.		<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as C.1.a through C.1.f.</p> <p><b>Findings:</b> Same as C.1.a through C.1.f.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as C.1.a through C.1.f.</p>									

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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Abner Ziganay, PT,</li> <li>2. Alonzo Webb, PT</li> <li>3. Andrea Cirotta, Acting Rehabilitation Therapy Chief</li> <li>4. Armanda Pruitt, SW</li> <li>5. Arza Izadian, MD, Neurology Consultant</li> <li>6. Ashvind Singh, PhD, Enhancement Treatment Coordinator</li> <li>7. Claudia Aries, SPT</li> <li>8. Denise Manos, Assistant Director of Nutrition Services</li> <li>9. Diane Levy PSW</li> <li>10. Doris Humphrey, RT</li> <li>11. Evangeline Ordonez, RD</li> <li>12. Gordin Wollin, PWS</li> <li>13. James Joseph, MD</li> <li>14. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>15. Jean-Woo Kim, Psychologist</li> <li>16. Jeou Hsing Lai, Psychiatrist</li> <li>17. Jocelyn Chen, PhD</li> <li>18. Jonathan Fogel, PhD, Substance Abuse Recovery Services Coordinator</li> <li>19. Karen Chong, Assistant Clinical Administrator</li> <li>20. Leticia Shamiyeh, RN</li> <li>21. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>22. Marsha Woods, RT</li> <li>23. Mary Ramirez, Assistant Director of Nutrition Services</li> <li>24. Michael Barsom, MD, Medical Director</li> <li>25. Mina Guirguis, Ph.D</li> <li>26. Monica Chabra, DO</li> <li>27. Nady Hanna, MD, Assistant Medical Director</li> <li>28. Portia Salvacion, Assistant Director of Nutrition Services</li> <li>29. Rebecca McClary, Acting Supervising Rehabilitation Therapist</li> </ol>

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		<p>30. Renee Kelly, Chief of Rehabilitation Therapy  31. Richard Hernandez, Shift Lead  32. Ruth Flores, Supervisor of Vocational Services  33. Sharon Smith Nevins, Executive Director  34. Sheri Greve, PsyD, Acting Chief of Psychology  35. Sung Kim, RN  36. Terez Henson, Supervising Rehabilitation Therapist  37. Veronica Hintog, Dietician</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 125 individuals: ADE, AG, AH, AJG, AL, AMB, AMM, AV, BE, BG, BMY, BRL, BS, CA, CAG, CAPR, CB, CBS, CDR, CG, CGB, CR, CRA, CW, DH, DK, DPP, EA, EAO, EEA, EF, EFL, FC, FCR, FN, FNK, FPR, GB, GCB, GEF, GS, GW, HC, HCR, HD, HEL, HH, IB, JC, JD, JDF, JEK, JEL, JF, JG, JGH, JJS, JLR, JLS, JMP, JP, JR, JRF, JRM, JTK, KB, KC, KD, KRS, LD, LH, LJC, LJO, LMN, LS, LT, MB, MC, MCF, MCL, MCM, MCT, MDS, MF, MH, ML, MM, MMV, MO, MR, MT, NA, NK, NM, NTM, PB, RCC, RM, RR, RS, SAL, SAM, SB, SC, SCG, SG, SH, SJC, SM, SM, SP, SR, SRM, SSG, TC, TE, TG, TM, TW, VC, VF, WAS, WO, WRM and ZC</li> <li>2. One WRP per team for the following 29 individuals: AB, AC, AMB, BE, CRA, EEA, GW, IB, JAM, JGH, JHM, JN, JRF, MJA, MLM, MN, MS, PC, SAL, SJC, SP, TAE, TDD, TPB, WHB, WRM, VA, YK, and ZC</li> <li>3. WRP and corresponding Focus 1 PSR Mall Progress Notes for the following six individuals: AJG, AMB, BE, CAG, MM, and WRM</li> <li>4. MSH document regarding Cognitive Remediation Groups previous vs. current reporting period and list of improvements made during review period.</li> <li>5. The following lesson plans: <ul style="list-style-type: none"> <li>• Substance Recovery (stage 1, 2, 3) for AMB</li> <li>• Managing Symptoms (challenged level) for AJG, AMB, CAG and NA</li> <li>• Medication and Wellness for AJG, AMB, CAG, NA, and WRM</li> </ul> </li> <li>6. The following Cognitive Remediation group lesson plans:</li> </ol>
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		<ul style="list-style-type: none"> <li>• Getting your Angries Out for JMP</li> <li>• Reminiscing (Memory Enhancement) for EEA</li> <li>• Here and Now for NA and EEA</li> <li>• Cognitive Rehabilitation for EEA and NTM</li> <li>• Specialized Treatment and Rehabilitation (STAR) for CW and MO</li> </ul> <ol style="list-style-type: none"> <li>7. Memorandum from MSH Executive Director to Court Monitor (March 10, 2010), Substance Abuse Director Coordinator</li> <li>8. DMH WRP Observation Monitoring summary data (August - January 2010/2011)</li> <li>9. DMH Chart Auditing Form summary data (August - January 2010/2011)</li> <li>10. DMH Clinical Chart Auditing Form summary data (August - January 2010/2011)</li> <li>11. DMH Substance Abuse Auditing Form summary data (August - January 2010/2011)</li> <li>12. Substance Abuse Clinical Outcome summary data (November 2009 - January 2011).</li> <li>13. Substance Abuse Process Outcome summary data (November 2009 - January 2011)</li> <li>14. Socrates A Assessment result summary data (November 2009 - January 2011)</li> <li>15. Expanded ASI Screening summary data (November 2009 - January 2011)</li> <li>16. Substance Abuse Consumer Satisfaction Survey summary data (November 2009 - January 2011)</li> <li>17. Substance Abuse C2o Table for Court Monitor 2010 Q4 - 2011 Q1</li> <li>18. Notes on Substance Abuse C2o Table for Court Monitor 2010 Q4 - 2011 Q1</li> <li>19. List showing daily supplemental activities offered during this review period (March 7-13, 2011)</li> <li>20. By Choice group monitoring tool</li> <li>21. Supplemental Provider Schedule</li> <li>22. Supplemental Activities Provider Audit Form</li> <li>23. Supplemental group preference individual request form.</li> </ol>
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		<p>24. Supplemental Provider Training Roster (eight staff trained)                  25. Supplemental Activities Provider Certification Process                  26. MSH Behavior Guideline and PBS Plan Development and Implementation Procedure                  27. A Guide to Developing a Milieu Plan                  28. MSH Neuropsychological Services Overview and Referral Guidelines                  29. Protocol for Evaluating Cognitive Functioning Using Observational Methods                  30. Participation in Treatment Questionnaire: Individual Interview 1.0                  31. MSH Non-Adherence Committee: Report for Quality Council - Summary                  32. PSR Services Mall Group Satisfaction Survey                  33. Psychology Services Non-Adherence Assessment                  34. Course Outline for the Civilly Committed                  35. Completed DMH Mall Facilitator Observation Monitoring Form</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Advanced Symptom Management</li> <li>2. PSR Mall Group: Cognitive Remediation</li> <li>3. PSR Mall Group: Medication and Wellness</li> <li>4. PSR Mall Group: Substance Recovery (stage 1, 2, 3) facilitated by Phil Black, Psychiatric Technician</li> <li>5. PSR Mall Group: Substance Recovery (stage 3, 4, 5) facilitated by LaTanya Lair, Psychiatric Technician</li> <li>6. PSR Mall Group: Substance Recovery (stage 3, 4, 5) facilitated by Nilakshini Wanagura, PsyD</li> <li>7. PSR Mall Group: WRAP 101</li> <li>8. PSR Mall Group: WRAP 201</li> <li>9. WRPC (Program III, unit 401) for quarterly review of JH</li> <li>10. WRPC (Program III, unit 409) for annual review of JMT</li> <li>11. WRPC (Program VI, unit 419) for monthly review of GCB</li> </ol>
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning	<b>Current findings on previous recommendation:</b>

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	<p>process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</p>	<p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 95% based on an average sample of 20% of the WRPCs held each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.b</p>	<p>Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:</p>	<p>Please see sub-cells for compliance findings.</p>
<p>C.2.b.i</p>	<p>initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.b.i to C.2.b.iii (August 2010 - January 2011). Based on an average sample of 100% of the A-WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p><b>Other findings:</b> A review of the charts of ten individuals admitted during the review period (AJG, AMB, BE, CAG, CRA, GW, MM, SAL, WRM and ZC) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.b.ii	<p>master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Based on an average sample of 52% of the 7-day WRPs, the facility reported a mean compliance rate of 100% with this requirement. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of ten individuals admitted during the review period (AJG, AMB, BE, CAG, CRA, GW, MM, SAL, WRM and ZC) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

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<p>C.2.b. iii</p>	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12<sup>th</sup> monthly review is the annual review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The following is a summary of the facility's data:</p> <table border="1" data-bbox="968 488 1625 716"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>64%</td> <td>96%</td> </tr> <tr> <td>Monthly</td> <td>15%</td> <td>95%</td> </tr> <tr> <td>Quarterly</td> <td>19%</td> <td>95%</td> </tr> <tr> <td>Annual</td> <td>21%</td> <td>96%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b> A review of the charts of ten individuals admitted during the review period (AJG, AMB, BE, CAG, CRA, GW, MM, SAL, WRM and ZC) found compliance in nine cases and partial compliance in one (ZC).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	64%	96%	Monthly	15%	95%	Quarterly	19%	95%	Annual	21%	96%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	64%	96%															
Monthly	15%	95%															
Quarterly	19%	95%															
Annual	21%	96%															
<p>C.2.c</p>	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>															

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	<p>history and previous response to such services;</p>	<p><b>Findings:</b>  MSH assessed its compliance using the DMH WRP Clinical Chart Auditing Form. The average sample was 100% of the relevant population for each sub-indicator during the review period (August 2010 - January 2011).</p> <table border="1" data-bbox="968 415 1862 938"> <tr> <td data-bbox="968 415 1062 599">2.</td> <td data-bbox="1062 415 1766 599"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1766 415 1862 599">98%</td> </tr> <tr> <td data-bbox="968 599 1062 711">2.a</td> <td data-bbox="1062 599 1766 711"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1766 599 1862 711">98%</td> </tr> <tr> <td data-bbox="968 711 1062 823">2.b</td> <td data-bbox="1062 711 1766 823"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1766 711 1862 823">100%</td> </tr> <tr> <td data-bbox="968 823 1062 935">2.c</td> <td data-bbox="1062 823 1766 935"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1766 823 1862 935">98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate for the overall main indicator of at least 90% from the previous review period.</p> <p><b>Other findings:</b>  This monitor reviewed the charts of 13 individuals who suffered from seizure disorders (CDR, CG, IB, JP, LMN, NA and SP) and/or a variety of cognitive disorders (CW, EAO, EEA, JMP, LMN, MO, NA and NTM). The reviews found evidence of sustained progress in the following areas:</p> <ol style="list-style-type: none"> <li>1. Review of the status of seizure activity for individuals diagnosed with seizure disorders;</li> <li>2. The formulation of learning-based objectives and interventions for</li> </ol>	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	98%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	98%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	100%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	98%
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	98%												
2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	98%												
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2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	98%												

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		<p>most individuals suffering from seizure disorders;</p> <ol style="list-style-type: none"> <li>3. Significant decrease in the number of individuals diagnosed with both seizure and cognitive disorders and receiving high-risk older generation anticonvulsant agents;</li> <li>4. Finalization of diagnosis for individuals suffering from dementias;</li> <li>5. Addressing the fall risk for individuals suffering from seizure and/or cognitive impairments, as appropriate;</li> <li>6. Neuropsychological testing for individuals suffering from cognitive impairments;</li> <li>7. Development of appropriate foci, objectives and/or interventions to address the needs of most individuals diagnosed with dementing illnesses, mental retardation and other cognitive impairments;</li> <li>8. No evidence of unjustified long-term use of anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments;</li> <li>9. Provision of formal and/or informal cognitive rehabilitation for individuals diagnosed with cognitive impairments; and</li> <li>10. The number and hours of groups that offer cognitive remediation or that address cognitive impairment as a secondary objective.</li> </ol> <p>This monitor found the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. The neurology consultation did not address the behavioral risks of continued phenytoin use in an individual who was diagnosed with seizure disorder and mental retardation and experienced significant behavioral abnormalities that appeared to complicate the management of her seizure disorder (LMN).</li> <li>2. The WRP did not document the status of an individual who developed new seizure activity during the interval (CG). However, disciplinary documentation adequately addressed the status of this individual.</li> <li>3. The objective statements for one individual suffering from a dementing illness (MO) and another individual suffering from seizure disorder (EEA) were incomprehensible.</li> </ol>
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		<p>Regarding the care of individuals suffering from substance use disorders, this monitor found persistent deficiencies in the current system of care, but this area is addressed in C.2.o.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p><b>Compliance:</b> Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH reported a compliance rate of 95% based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered</p>

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		<p>for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p><b>Recommendation 2, September 2010:</b> Continue efforts to streamline the WRPs to minimize duplication (in WRPs and the psychiatric progress notes) in the documentation of planned modifications of treatment for individuals who require the use of restrictive interventions.</p> <p><b>Findings:</b> DMH has finalized efforts to streamline the WRPs and implementation is pending. This monitor has requested samples of streamlined WRPs from each facility prior to the April 2011 tour of ASH.</p> <p><b>Other findings:</b> This monitor reviewed one WRP per team for the following 29 individuals: AB, AC, AMB, BE, CRA, EEA, GW, IB, JAM, JGH, JHM, JN, JRF, MJA, MLM, MN, MS, PC, SAL, SJC, SP, TAE, TDD, TPB, WHB, WRM, VA, YK, and ZC. The review found general evidence of substantial compliance with this requirement of the EP.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Implement the streamlined WRP format.</li> </ol>
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	96%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in §	98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

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	[III.B.4.b] above;	
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	98%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	95%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Same as in C.1.a.</li> </ul> <p><b>Findings:</b></p> <p>Using the DMH WRP Chart Auditing Form, MSH reported a compliance rate of 94% based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance</p>

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		<p>rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b>  This monitor reviewed the records of 15 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.e. Fourteen records were in substantial compliance (AG, BE, CB, EF, EFL, GEF, IB, JLS, JP, JR, JRM, LT, SC and VF) and one individual record was not in compliance (JDF).</p> <p>This monitor also reviewed the records of 11 individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments during the review period to assess compliance with the requirements of C.2.e. Five records were in substantial compliance (AV, BE, JLR, LS and MR); three records were in partial compliance (BS, MCT and MT); and four records were not in compliance (BRL, JEL and MH).</p> <p>Finally, this monitor reviewed the records of 16 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to monitor this requirement.</p>
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health,	Please see sub-cells for compliance findings.

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	health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010 - January 2011), and reported a mean compliance rate of 93%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in all cases (AJG, AMB, BE, CAG, MM and WRM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH reported a compliance rate of 93% based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in all cases (AJG, AMB, BE, CAG, MM and WRM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Avoid the use of generic objectives that do not address the assessed needs of the individuals.</li> </ul> <p><b>Findings:</b> The facility reported a mean compliance rate of 93%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in all cases (AJG, AMB, BE, CAG, MM and WRM).</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure consistency in differentiating the stages of preparation and contemplation in the formulation of objectives.</li> </ul> <p><b>Findings:</b> The facility reported a mean compliance rate of 98%. However, this rate was in conflict with the rate provided for a related indicator (#3) in the revised data presented in C.2.o (this rate was 77%).</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in two charts (AJC and BE), partial compliance in two (AMB and WRM) and noncompliance in two (CAG and MM).</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement and provide analysis of comparative data considering data presented in C.2.o.</p>
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist	<p><b>Current findings on previous recommendation:</b></p>

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	<p>the individual to meet his/her needs as specified in the objective;</p>	<p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 95%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in all cases (AJG, AMB, BE, CAG, MM and WRM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Address systemic issues that result in inconsistent/incorrect data in the WaRMMS database so that the database can serve as a source of valid and reliable data for monitoring, analysis and decision-making.</li> <li>• Continue to monitor hours of active treatment (scheduled and attended).</li> <li>• Continue to address factors related to inadequate scheduling by the WRPTs, inaccurate and inconsistent reporting of hours scheduled on the WRP and MAPP, and inadequate participation by individuals.</li> </ul> <p><b>Findings:</b> MSH presented the following data for the review period (August 2010-January 2011):</p>

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		<table border="1"> <thead> <tr> <th colspan="3">Number of individuals by category</th> </tr> <tr> <th></th> <th>Mean scheduled</th> <th>Mean attended</th> </tr> </thead> <tbody> <tr> <td>Hours</td> <td></td> <td></td> </tr> <tr> <td>0-5</td> <td>37</td> <td>39</td> </tr> <tr> <td>6-10</td> <td>37</td> <td>41</td> </tr> <tr> <td>11-15</td> <td>61</td> <td>183</td> </tr> <tr> <td>16-20</td> <td>504</td> <td>377</td> </tr> </tbody> </table>		Number of individuals by category				Mean scheduled	Mean attended	Hours			0-5	37	39	6-10	37	41	11-15	61	183	16-20	504	377
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		<p>The data in the tables above indicate that MSH continues to schedule a large number of individuals in the 20-hour category. However, the attendance of the individuals at these categories has dropped in comparison to the previous review period (377 attended versus 522</p>																						

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attended at the 16-20 hours category); at the same time the number scheduled and attended at the 11-15 hours category is much higher during this review period (73 for the previous period and 183 for the current period).

This monitor reviewed the records of 10 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found that with one exception, the individuals whose records were reviewed were enrolled in 17-20 hours of PSR Mall services per week; there appears to be an error of documentation in the WRP of MF as discussed below.

In four out of ten records, WRP scheduled hours matched the MAPP scheduled hours. In almost all cases, the MAPP attended hours are low. MSH has not fully implemented its non-adherence protocol and followed up with appropriate interventions to ensure that individuals receive the necessary support and motivation to attend their scheduled Mall hours.

The following table summarizes the monitor's findings:

Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours
ADE	20	20	19
GS	22	22	0
JC	20	15	3
JEK	17	21	7
JR	18	18	5.2
MF	3	20	10
PB	23	29	14
SM	22	20	11
TC	21	23	9
TE	20	20	0

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		<p>Something appears to be incorrect with MF's WRP scheduled hours. There is wide discrepancy in the groups listed under the Present Status section (page 5 of the WRP, for WRPC date 9/14/2010), with the following groups listed under Current Groups: WRP 101, Fun &amp; Fitness, Substance Recovery 101, Volleyball, Walking for Cardio Health, Nutrition &amp; Wellness, Managing Symptoms, and Coping Skills. However, there are no active interventions for Foci 1, 3, 5, and 10. The only group listed under active interventions is WRAP 101, for Focus 11.</p> <p>MSH should review, analyze, and correct data discrepancies among the various sources. It is difficult to identify relevant factors causing the discrepancy and corrective actions to take in the absence of valid and reliable data.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f. vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH assessed its compliance based on a mean sample of 20% of individuals eligible for off-site PSR Mall activities in the review period (August 2010-January 2011) and reported a mean compliance rate of 92%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>MSH's documentation for off-site programming of civilly committed individuals showed that the facility is actively planning off-site programming for individuals who meet certain psychiatric and behavioral criteria. The documentation also indicates that individuals are programmed for off-site activities for 120 minutes (two sessions 9.40AM and 3.15PM, on Mondays, Wednesdays, and Fridays). Documentation for 18 individuals (EF, JF, JR, KB, KD, KRS, LJC, LJO, MM, MMV, NM, PB, RS, SB, SH, SM, TM and WO) indicated that all of them were on off-site schedules. For example, PB's off-site activities are noted under Focus 11. The objective for PB is to learn community living skills (money management, leisure awareness, safety, making appointments, independent living skills, transportation, and hygiene and grooming). The interventions include going to the bank, stores, and restaurants to practice money management skills, and to the library, movies, hairdresser, and laundromat to practice independent living skills in the community. Reviews of the charts of other individuals (MCL and MF) found documentation that the individuals' current psychiatric status prevents from engaging in PSR group activities in the community. It is important that the WRPTs state the type and nature of the behaviors they consider as barriers to the individual's community participation, beyond simply stating that psychiatric behaviors are barriers.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.f. viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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	<p>State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on a mean sample of 20% of the quarterly and annual WRPs due each month for the review period (August 2010-January 2011) and reported a mean compliance rate of 93%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found substantial compliance in eight records (DPP, JTK, ML, MR, SJC, TG, WAS and ZC). The groups were appropriate for the objectives and included the groups necessary to address the individual's discharge requirement and clinical needs. However, this was not the case for one record (MF), in which active interventions were missing for a number of foci and therefore groups were missing for the individual's objectives to be achieved.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g	<p>Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>

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<p>C.2.g.i</p>	<p>revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure consistency in revising objectives to address the changing needs of the individuals.</li> </ul> <p><b>Findings:</b> See C.2.t, sub-items 11.d and 11.e, for the facility's self-monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in four charts (AJG, AMB, BE and CAG) and partial compliance in two (MM and WRM).</p> <p>Additionally, this monitor reviewed the records of eight individuals receiving direct speech, occupational, and/or physical therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.g.ii</p>	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure that the Present Status section of the WRPs does not lose</li> </ul>

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	<p>risk factors);</p>	<p>track of episodes of seclusion/restraints during the WRP interval.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, the facility reported a compliance rate of 95% based on an average sample of 100% of individuals placed in seclusion and/or restraint each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period. The following table outlines the reviews:</p> <table border="1" data-bbox="968 743 1856 1052"> <thead> <tr> <th>Individual</th> <th>Date of seclusion and/or restraint</th> <th>Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td>BMV</td> <td>1/26/11</td> <td>2/10/11</td> </tr> <tr> <td>FCR</td> <td>12/3/10</td> <td>12/6/10</td> </tr> <tr> <td>FNK</td> <td>11/5/10</td> <td>12/16/10</td> </tr> <tr> <td>JJS</td> <td>1/11/11</td> <td>1/17/11</td> </tr> <tr> <td>LJO</td> <td>12/6/10</td> <td>1/26/11</td> </tr> <tr> <td>RCC</td> <td>12/3/10</td> <td>1/11/11</td> </tr> </tbody> </table> <p>This review focused on the documentation of the circumstances leading to the use of restrictive interventions, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found substantial compliance in five charts and partial compliance in one (FNK).</p> <p><b>Compliance:</b> Substantial.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	BMV	1/26/11	2/10/11	FCR	12/3/10	12/6/10	FNK	11/5/10	12/16/10	JJS	1/11/11	1/17/11	LJO	12/6/10	1/26/11	RCC	12/3/10	1/11/11
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g.iii	<p>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure consistent documentation of individualized discharge criteria and of the individual's progress towards discharge.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 96% based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals (B AJG, AMB, BE, CAG, MM and WRM). The review focused on the documentation of discharge criteria and the discussion of the individual's progress towards discharge. The review found substantial compliance in five charts and partial compliance in one (WRM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as</p>	<p><b>Current findings on previous recommendations:</b></p>

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	<p>specified in the therapeutic and rehabilitation service plan.</p>	<p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH reported a compliance rate of 94% based on an average sample of 20% of the quarterly and annual WRP. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other Findings:</b> This monitor reviewed the charts of six individuals (AJG, AMB, BE, CAG, MM and WRM). The review focused on the documentation of the individual's attendance and progress in Mall groups that address the individual's needs under Focus 1 of the WRP. The review found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.h	<p>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</p>	<p>Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.</p>
C.2.i	<p>Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:</p>	<p><b>Compliance:</b> Substantial.</p>

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<p>C.2.i.i</p>	<p>is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in 13 of the WRPs in the charts (CW, HC, HEL, HH, JR, MC, ML, NK, PB, SM, SRM, TC and VC). A number of deficiencies, including the absence of an appropriate Mall group, incorrect stages of change, and poor correspondence between the objectives and recommended PSR Mall services, were noted in the remaining two WRPs (LJC and MF). For example, LJC is not in a substance abuse recovery group, the objective for substance abuse foci is left as inactive without any explanation in the Present Status section of the WRP, and the focus and objective for Focus 11 is not well aligned.</p> <p><b>Other findings:</b> This monitor reviewed the records of 15 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p>
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Monitor this requirement and present data.</p> <p><b>Findings:</b> Using the DMH WRP Chart Audit Form, MSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="968 673 1866 748"> <tr> <td>7.</td> <td><i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that seven of the WRPs in the charts contained objectives written in a measurable/ observable manner (DK, FN, JRF, PB, SG, WAS and ZC) and one did not (MH).</p> <p>A review of the records of nine individuals found that the objectives in seven of the WRPs in the charts were directly linked to a relevant focus of hospitalization (G, DK, JRF, PB, SG, WAS and ZC) and two were not (FN and MH).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	7.	<i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i>	93%
7.	<i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i>	93%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's	<p><b>Current findings on previous recommendation:</b></p>			

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	Wellness and Recovery Plan	<p><b>Recommendation, September 2010:</b> See C.2.f.viii.</p> <p><b>Findings:</b> See C.2.f.viii.</p> <p><b>Current recommendation:</b> See C.2.f.viii.</p>			
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 5% of Mall group facilitators each month during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="968 894 1866 971"> <tr> <td>15.</td> <td><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	96%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	96%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 20% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of nine individuals found that the individual's vulnerabilities were documented in the case formulation section in all nine of the WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (CG, CW, HD, LD, MC, MH, SG, SM and SRM).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>																				
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility provided the following data pertaining to individuals in need of cognitive remediation:</p> <table border="1" data-bbox="968 1117 1801 1421"> <thead> <tr> <th colspan="5">Individuals in need of Cognitive Remediation during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>144</td> <td>129</td> <td>145</td> <td>132</td> </tr> <tr> <td>Receiving service</td> <td>53</td> <td>67</td> <td>90</td> <td>92</td> </tr> </tbody> </table>	Individuals in need of Cognitive Remediation during the current and previous three Mall terms						Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	With identified need	144	129	145	132	Receiving service	53	67	90	92
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		<table border="1"> <tr> <td>% receiving service</td> <td>37%</td> <td>52%</td> <td>62%</td> <td>70%</td> </tr> </table>	% receiving service	37%	52%	62%	70%					<p>Using the DMH WRP Facilitator Mall Observation Monitoring Form, MSH assessed compliance based on an average sample of 5% of the Mall group facilitators each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 96%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals (CG, CGB, DPP, GB and WAS) found that cognitive screening had been conducted in three of them (CGB, DPP and WA); cognitive screening/assessment had been attempted by the examiner in the remaining two individuals (CG and GB) but the individuals were either uncooperative or too psychiatrically unstable at the time to participate in the assessment. The examiners had indicated plans to address the assessment at a later date. Follow-up review found that the cognitive screening status had been documented in the Present Status section of WRPs.</p> <p>A review of the documented cognitive levels against their Mall schedules, and observation of them in their Mall groups (Substance Abuse Recovery and Cognitive Remediation Mall groups) found that the group levels in the schedules and the cognitive levels of the individuals were aligned, and observations of Mall groups found that facilitators' presentations (language used, material used, and techniques utilized) were at the individuals' level of understanding.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
% receiving service	37%	52%	62%	70%								
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the	<b>Current findings on previous recommendations:</b>										

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	<p>Wellness and Recovery Plan review process;</p>	<p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that all group and individual therapy providers provide the WRPTs with meaningful progress reports on all individuals prior to each individual's scheduled WRP review.</li> <li>• Use the data from monthly Mall Progress Notes in the WRP review process.</li> </ul> <p><b>Findings:</b>  The facility reported that 91% of the 13,246 Mall progress notes that were due in the last month of the review period were completed.</p> <p>A review of the charts of eight individuals (BE, BMY, JGH, LJO, MCM, MDS, SAM and TG) found that all eight contained progress notes, and the notes had been reviewed and relevant information incorporated into the Present Status section of the individual's WRP. However, there were internal inconsistencies in some of the Mall progress notes (e.g., progress and participation was rated as good when attendance was listed as zero, as in the case for LJO). In addition, the Mall progress notes do not document the individual's progress in his/her objectives as documented in the individual's WRP. WRPTs cannot make determination on the individual's progress without such feedback from the Mall facilitators through their progress notes.</p> <p><b>Other findings:</b>  This monitor reviewed the records of 15 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.i.vii. Thirteen records were in substantial compliance (AG, BE, CB, EF, EFL, GEF, IB, JLS, JP, JR, JRM, LT and SC); one record was in partial compliance (JDF); and one record was not in compliance (VF).</p>
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered. During the review period, MSH provided a mean of 11,729 hours of Mall groups per month.</p> <p>Documentation and information from the Mall Director indicated that a number of new Mall groups had been developed and implemented during this review period including: Cognitive Behavior Therapy (CBT) for Fear and Anxiety, CBT for Psychosis, Cognitive Rehabilitation 2, PTSD group, DBT through Music, and Court Competency Groups. The Mall Director continues to meet all requests for additional Mall groups. Requests for new groups or changes to an individual's current group are made directly online by the WRPTs. According to the Mall Director, individuals had requested a "Healthy Relationships" Mall group, and the Mall Director is in processing of establishing this group. This monitor recommends that the Mall Director work with the Social Work staff involved in the Family Therapy groups in developing an integrated curriculum and lesson plans to ensure that the information from these two groups is compatible.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
C.2.i.ix	<p>is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;</p>	<p><b>Current findings on previous recommendations:</b></p>

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		<p><b>Recommendation, September 2010:</b> Continue to monitor this requirement and present data.</p> <p><b>Findings:</b> Since the previous review, one individual (GB) was placed on bed-bound status between 1/24/11 and 2/10/11. According to facility report, the individual received 15 hours of active treatment between 1/24 and 1/31/11 (end of the review period). This monitor's findings from document review regarding GB's services during his bed-bound status are in agreement with the facility's report. However, it appears that GB's bed-bound status was due to pain and behavioral issues and not due to physical limitation. GB carries multiple diagnoses of psychiatric and physical disorders (including Schizoaffective Disorder, depressive type, Paralysis Agitans, and hypertrophy of prostate with urinary obstruction). He reports extreme pain, especially in his groin area. This monitor observed GB's WRPC, and his primary interest at the conference was to address the reportedly severe pain in his penis. GB uses a wheelchair to move around due to his reported pain.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement and present data.</p>
C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that Mall groups and individual therapies are cancelled rarely, if ever.</li> <li>• Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.</li> <li>• Ensure that administrators facilitate a minimum of one Mall group per week.</li> </ul>

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**Findings:**

MSH presented the following data regarding cancellation of Mall groups:

	Aug	Sep	Oct	Nov	Dec	Jan	Mean
Groups scheduled	3088	2528	2832	3120	2837	2929	2889
Groups cancelled	193	250	231	294	245	250	244
Cancellation rate	6%	10%	8%	9%	9%	9%	8%

The mean cancellation rate was 12% in the previous review period.

The facility presented the following data regarding Mall group facilitation by discipline:

<b>Average weekly hours provided by discipline</b>		
	Previous review period	Current review period
Psychiatry Admissions (4)	2	1.5
Psychiatry Long-Term (8)	3.5	2.5
Psychology Admissions (5)	2.5	2.75
Psychology Long-Term (10)	6	5.56
Social Work Admissions (5)	3.5	2.75
Social Work Long-Term (10)	8	4.7
Rehab Therapy Admissions (7)	6	7
Rehab Therapy Long-Term (15)	14	6.5
Nursing (10)	5	1.72

As the table above shows, participation by most disciplines has dropped during this review period, some significantly as in the case of Nursing and Rehab Therapy Social Work on the long-term units. Discipline heads need

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		<p>to ensure that staff keeps their Mall schedules except under certain circumstances and that too with appropriate approval.</p> <table border="1" data-bbox="968 302 1860 683"> <thead> <tr> <th>Discipline</th> <th>Hours Scheduled/ Week</th> <th>Hours Provided/ Week</th> <th>Percentage of Scheduled Hours Fulfilled</th> </tr> </thead> <tbody> <tr> <td>Psychiatry</td> <td>114</td> <td>91</td> <td>80%</td> </tr> <tr> <td>Psychology</td> <td>235</td> <td>188</td> <td>80%</td> </tr> <tr> <td>Social Work</td> <td>279</td> <td>199</td> <td>71%</td> </tr> <tr> <td>Rehab Therapy</td> <td>443</td> <td>309</td> <td>70%</td> </tr> <tr> <td>Nursing</td> <td>1007</td> <td>580</td> <td>56%</td> </tr> <tr> <td>Other</td> <td>243</td> <td>178</td> <td>73%</td> </tr> <tr> <td>Administration</td> <td>48</td> <td>29</td> <td>60%</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Discipline	Hours Scheduled/ Week	Hours Provided/ Week	Percentage of Scheduled Hours Fulfilled	Psychiatry	114	91	80%	Psychology	235	188	80%	Social Work	279	199	71%	Rehab Therapy	443	309	70%	Nursing	1007	580	56%	Other	243	178	73%	Administration	48	29	60%
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C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="968 1130 1860 1373"> <thead> <tr> <th></th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1716</td> <td>1966</td> <td>1847</td> <td>1734</td> <td>2260</td> <td>1885</td> <td>1901</td> </tr> <tr> <td>Hours provided</td> <td>1274</td> <td>1260</td> <td>1148</td> <td>1160</td> <td>1488</td> <td>1138</td> <td>1240</td> </tr> <tr> <td>Completion rate</td> <td>74%</td> <td>64%</td> <td>62%</td> <td>67%</td> <td>66%</td> <td>60%</td> <td>66%</td> </tr> </tbody> </table>		Aug	Sep	Oct	Nov	Dec	Jan	Mean	Hours scheduled	1716	1966	1847	1734	2260	1885	1901	Hours provided	1274	1260	1148	1160	1488	1138	1240	Completion rate	74%	64%	62%	67%	66%	60%	66%
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		<p>According to MSH, the data in the above table is unreliable due to WaRMMS issue in printing duplicate rosters.</p> <p>MSH continues to provide supplementary activities to individuals at its facility. Individuals had the opportunity to participate a mean of 17 hours of supplemental activity a week during this review period. MSH continues to improve the services, and in this light has developed and implemented provider audits, schedules, staff training, and peer-facilitators. Charts of individuals now show good documentation of an individual's scheduling and participation in their supplemental and enrichment activities in the Present Status section as well as in the appropriate sections of the Focus, Objectives, and Interventions. The facility has advertised for "peer facilitators" and teams are to recommend individuals to serve as such. Once identified, the peer facilitator will be given training and certified before acting as a peer facilitator. The facility has developed criteria for peer facilitator hiring as well as for termination. The position is expected to be a paid position akin to an IT position.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the Therapeutic Milieu Observation Monitoring Form, MSH assessed its compliance based on observations of an average sample of 42% of the AM and PM shifts on all units in the facility. The following table summarizes the facility's data:</p>

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		<table border="1"> <tr> <td>1.</td> <td><i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i></td> <td>93%</td> </tr> <tr> <td>3.</td> <td><i>There is evidence of a unit recognition program.</i></td> <td>70%</td> </tr> <tr> <td>4.</td> <td><i>The posted unit rules reflect recovery language and principles.</i></td> <td>62%</td> </tr> <tr> <td>5.</td> <td><i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i></td> <td>70%</td> </tr> <tr> <td>6.</td> <td><i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Staff is observed actively engaged with the individuals.</i></td> <td>95%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful manner.</i></td> <td>99%</td> </tr> <tr> <td>9.</td> <td><i>Situations involving privacy occurred and they were properly handled.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i></td> <td>95%</td> </tr> </table>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	93%	2.	<i>There is some staff interacting (e.g., engaged in conversation or activity) with individuals.</i>	93%	3.	<i>There is evidence of a unit recognition program.</i>	70%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	62%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	70%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	100%	7.	<i>Staff is observed actively engaged with the individuals.</i>	95%	8.	<i>Staff interact with individuals in a respectful manner.</i>	99%	9.	<i>Situations involving privacy occurred and they were properly handled.</i>	100%	10.	<i>If during the observation period, there is a situation in which one or more individuals are escalating, and staff reacts calmly.</i>	95%	
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C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards	<p><b>Other findings:</b> WRPs of five individuals were reviewed and milieu interventions for all active interventions under Focus 1 and 3 were evaluated. All five WRPs had included milieu interventions for active interventions. Two WRPs (GB and MCF) contained milieu interventions appropriate to the active intervention. In the remaining three individuals, the milieu interventions were general and were not objective/intervention-specific (GCB, LJO and SAM). For example, the milieu intervention for SAM was written as "encourage to utilize learned skills" for an objective that had to do with medication and the individual was to learn about how medications affect the individual's mental illness; a milieu intervention for GCB was written as "encourage to go to groups so he can learn about his mental illness" for an objective that dealt with "reporting two symptoms he experiences." Milieu interventions should be more than just "encouraging." Staff could be reviewing, asking, modeling, reading, discussing, etc. appropriate to the target behavior(s) and what is being learned in the PSR Mall services and/or individual therapies.</p> <p>A good example can be found in Focus 3, Intervention 3.2.1.2, in MCF's WRP. Here, the milieu intervention was written as "Unit staff will assist Mr. F in identifying some reasons for his acting out aggressively toward others, and to assist him in managing his anger in a more pro-social manner."</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p> <p><b>Current findings on previous recommendations:</b></p>												

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of care.

**Recommendations 1 and 2, September 2010:**

- Track and review participation of individuals in scheduled group exercise and recreational activities.
- Implement corrective action if participation is low.

**Findings:**

The facility presented the following data:

Exercise Groups Offered vs. Needed						
	Aug	Sep	Oct	Nov	Dec	Jan
Number of groups offered	15	15	15	17	17	17
Number of groups needed @ 1x/wk	13	13	13	15	15	15
Offered/needed	>100%	>100%	>100%	>100%	>100%	>100%

The facility also presented the following data:

BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned
25 - 30	159	150	94%
31 - 35	99	89	90%
36 - 40	41	38	93%
>40	26	25	96%

As the first table above shows, MSH is providing sufficient numbers of Exercise groups to allow individuals who need it to be placed in one. The second table shows that over 90% of individuals with high BMIs were enrolled in one or more exercise groups. MSH would benefit from tracking and trending BMI/weight changes in these individuals as a way to study their participation and program effectiveness. In turn, this will assist the WRPT, exercise group facilitators, and dieticians to review their areas connected with the individual's needs from their program perspectives.

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		<p>This monitor reviewed records of seven individuals with high BMIs. All seven individuals had been enrolled in an exercise group and/or had dietary modification as a means of addressing their high BMI's (BE, BMY, DPP, FC, JG, MDS and TG). Appropriate objectives and interventions were present in their relevant sections and were documented in the Present Status section of the individual's WRP.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
C.2.k	<p>Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH C2k Family Therapy Auditing Form, MSH assessed its compliance using the following indicators (size of sample as a percentage of relevant population noted in parentheses):</p> <table border="1" data-bbox="968 1081 1860 1414"> <tr> <td data-bbox="968 1081 1037 1227">1.</td> <td data-bbox="1037 1081 1730 1227"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1730 1081 1860 1227">96% (100%)</td> </tr> <tr> <td data-bbox="968 1227 1037 1414">2.</td> <td data-bbox="1037 1227 1730 1414"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for</i></td> <td data-bbox="1730 1227 1860 1414">86% (23%)</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	96% (100%)	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for</i>	86% (23%)
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C.2.1	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational	<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1 and 3; the compliance rate for item 2 was 88% in the previous review period.</p> <p>This monitor reviewed records of five individuals (BE, DPP, MDS, MM and TG). All five individuals had been screened for family therapy needs. TG is in the process of a family therapy assessment. All of the remaining four individuals are receiving information, material, education, and/or therapy depending upon the family interest and availability. For example, MM's mother is in contact with SW staff to obtain information on MM's progress but would like to keep direct contact with MM to a minimum due to MM's excessive demands from her; and SW staff is working with BE and the parent to repair their dysfunctional relationship.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>						

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	<p>nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p><b>Findings:</b> Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on a 16% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="968 414 1866 790"> <tr> <td data-bbox="968 414 1062 492">1.</td> <td data-bbox="1062 414 1772 492"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1772 414 1866 492">95%</td> </tr> <tr> <td data-bbox="968 492 1062 565">2.</td> <td data-bbox="1062 492 1772 565"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1772 492 1866 565">97%</td> </tr> <tr> <td data-bbox="968 565 1062 638">3.</td> <td data-bbox="1062 565 1772 638"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1772 565 1866 638">92%</td> </tr> <tr> <td data-bbox="968 638 1062 711">4.</td> <td data-bbox="1062 638 1772 711"><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td data-bbox="1772 638 1866 711">96%</td> </tr> <tr> <td data-bbox="968 711 1062 790">5.</td> <td data-bbox="1062 711 1772 790"><i>There are appropriate interventions for each objective.</i></td> <td data-bbox="1772 711 1866 790">95%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the WRPs of 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that MSH has continued to make improvements in this area since the last review, with the result that the majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions. This comports with MSH's data.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	95%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	97%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	92%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	96%	5.	<i>There are appropriate interventions for each objective.</i>	95%
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C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because MSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as C.2.o.</p> <p><b>Findings:</b> Same as C.2.o.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Same as C.2.o.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Ensure stability in leadership of Substance Use Services.</p> <p><b>Findings:</b> The facility recruited a new Coordinator of Substance Abuse Services, Jon</p>

		<p>Fogel, PhD, who reportedly has expertise in substance abuse services, assessment, and statistical analysis.</p> <p><b>Recommendations 2 and 3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Present process and clinical outcome data using consistent indicators and methodology.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</li> </ul> <p><b>Findings:</b></p> <p>MSH presented process and clinical outcome data for this review period. However, the data are not presented here due to the fact that the initial data set was clearly incomplete and inconsistent both internally and with data presented during the last review period. This monitor provided the facility an opportunity to correct its data following the tour. However, the revised data were unacceptable due to the following problems:</p> <ol style="list-style-type: none"> <li>1. The numbers of individuals who advanced in the stage (or sustained in maintenance), the individuals who refused treatment and the individuals who did not advance did not add up to the number of individuals enrolled on the first day of the quarter. There was no explanation of this phenomenon, especially that the data added up during the previous review period.</li> <li>2. During this review period, the facility reported that 100% of individuals were screened by SAS (157 during October to December 2010 and 195 during January to March 2010). However, these data were inconsistent with other data that 406 and 402 individuals were referred to SAS treatment, that 295 and 390 individuals were enrolled in treatment and that 406 and 402 were enrolled on the first day of quarter during the same time periods.</li> <li>3. During the previous review period (July to September 2010), the facility reported that 267 individuals were enrolled in AA meetings but</li> </ol>
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		<p>that only 120 attended. During this review period, 410 were reportedly enrolled and all of them attended (October to December 2010). The report of 100% compliance with attendance is highly unlikely.</p> <p>4. During the last review period (July to September 2010), the facility reported that 112 individuals were enrolled in NA groups and that 30 of them attended. However, during this review period (October to December 2010), the facility reported "not applicable" for this data without explanation.</p> <p>The facility reported that a disproportionate number of Substance Abuse and Recovery groups were cancelled relative to other groups, including Medication and Wellness, Symptom Management etc. However, the data appeared to indicate that the number of individuals enrolled and receiving services remained high overall.</p> <p>The facility's consumer satisfaction surveys data indicated that during the quarter of October to December 2010, the majority of individuals agreed with the indicators of learning new skills (83 vs. 17), understanding of information (74 vs. 10) and finding the groups helpful (72 vs. 12) and the leaders respectful (70 vs. 14).</p> <p><b>Findings:</b> Using the DMH Substance Abuse Auditing Form, MSH assessed its compliance with this requirement based on an average sample of 18% of individuals with a current diagnosis of substance abuse (August 2010 - January 2011). The initial data set included clerical errors and the facility corrected its data following the tour. The following is a summary of the revised data:</p> <table border="1" data-bbox="968 1263 1866 1414"> <tr> <td data-bbox="968 1263 1062 1338">1.</td> <td data-bbox="1062 1263 1770 1338"><i>Substance abuse is integrated into the case formulation and discussed in the Present Status.</i></td> <td data-bbox="1770 1263 1866 1338">89%</td> </tr> <tr> <td data-bbox="968 1338 1062 1414">2.</td> <td data-bbox="1062 1338 1770 1414"><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td data-bbox="1770 1338 1866 1414">97%</td> </tr> </table>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the Present Status.</i>	89%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	97%
1.	<i>Substance abuse is integrated into the case formulation and discussed in the Present Status.</i>	89%						
2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	97%						

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		<table border="1"> <tr> <td data-bbox="955 186 1060 264">3.</td> <td data-bbox="1060 186 1770 264"><i>There is at least one objective related to the individual's stage of change.</i></td> <td data-bbox="1770 186 1864 264">77%</td> </tr> <tr> <td data-bbox="955 264 1060 342">4.</td> <td data-bbox="1060 264 1770 342"><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td data-bbox="1770 264 1864 342">83%</td> </tr> <tr> <td data-bbox="955 342 1060 453">5.</td> <td data-bbox="1060 342 1770 453"><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td data-bbox="1770 342 1864 453">82%</td> </tr> <tr> <td data-bbox="955 453 1060 565">6.</td> <td data-bbox="1060 453 1770 565"><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td data-bbox="1770 453 1864 565">77%</td> </tr> </table>	3.	<i>There is at least one objective related to the individual's stage of change.</i>	77%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	83%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	82%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	77%	
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		<p>Comparative data indicated maintenance of a compliance rate of at least 90% only for item 2. In the previous period, the compliance rates for items 1, 3 4, 5 and 6 were 91%, 96%, 92%, 91% and 94% respectively. The facility's analysis of the data revealed several systemic issues related to oversight and monitoring of the SAS Program and WRPT performance. Other issues identified were the schedule and timeliness of the SAS audits and lack of feedback loop to Discipline Seniors for corrective actions. Subsequent to the tour, the facility's Executive Director provided a plan of correction that appeared to be adequate, if properly implemented.</p> <p>This monitor's findings in C.2.f.iv are relevant to this area.</p> <p><b>Recommendation 4, September 2010:</b>          Improve group interventions to ensure proper engagement of attendees, relevance to the needs of individuals and practice during sessions, as appropriate.</p> <p><b>Findings:</b>          This monitor and one of his experts observed the following PSR Mall Groups:</p> <p>1. Substance Recovery (stage 1, 2, 3) facilitated by Phil Black, Psychiatric</p>													

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		<p>Technician;</p> <ol style="list-style-type: none"> <li>2. WRAP 101, facilitated by F. Forbes, PsyD; and</li> <li>3. Substance Recovery (stage 3, 4, 5) facilitated by LaTanya Lair, Psychiatric Technician.</li> </ol> <p>In one group, none of the scheduled individuals (#3) attended the session. Upon interview, the facilitator adequately discussed the group procedure and topics. In the other two groups, there was evidence of adequate engagement of the individuals, course content, facilitator knowledge and relevance of the topics to the individuals' needs. However, in one of these two groups, the facilitator did not appear to maintain an adequate professional boundary throughout group time, allowing some individuals to act in a manner that was too friendly and at times mischievous during the session.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure stability in the leadership of Substance Use Services and ensure proper oversight of services.</li> <li>2. Present and ensure accuracy of process and clinical outcome data using consistent indicators and methodology.</li> <li>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</li> <li>4. Continue to monitor this requirement and implement corrective actions to improve compliance.</li> </ol>
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.

**Findings:**

Using the DMH Mall Facilitator Observation Monitoring Form, MSH assessed its compliance based on an average sample of 5% of Mall facilitators each month during the review period (August 2010-January 2011):

		Previous review period	Current review period
1.	<i>Instructional skills</i>	97%	95%
2.	<i>Course structure</i>	95%	94%
3.	<i>Instructional techniques</i>	99%	95%
4.	<i>Learning process</i>	93%	96%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.

Using the DMH Mall Facilitator Observation Monitoring Form MSH assessed compliance from observation of an 5% sample of all facilitators during the review months (August 2010-January 2011):

1.	<i>The session starts and ends within 5 minutes of the designated starting and ending time.</i>	95%
2.	<i>The facilitator greets participants to begin the session.</i>	100%
3.	<i>The facilitator reviews work from the prior session.</i>	94%
4.	<i>The facilitator introduces the day's topic and goals.</i>	96%
5.	<i>The facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	95%
6.	<i>The facilitator makes an attempt to engage each participant during the group.</i>	94%
7.	<i>The facilitator attempts to keep all participants "on</i>	95%

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			<i>task" during the session.</i>	
		8.	<i>The facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	95%
		9.	<i>The facilitator attempts to test the participants understanding.</i>	96%
		10.	<i>The facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	92%
		11.	<i>The facilitator summarizes the work done in the session.</i>	94%
		12.	<i>The facilitator/co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	95%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	94%
		14.	<i>Lesson plan is available and followed.</i>	93%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor observed six Mall groups (Substance Abuse Recovery Stages 3.4.5; WRAP 101; WRAP 201; Medication and Wellness; Advanced Symptom Management; and Cognitive Remediation). The findings from observation of these Mall groups are as follows:</p> <ul style="list-style-type: none"> <li>• The group facilitators were prepared and enthusiastic.</li> <li>• The facilitators were knowledgeable in the course content.</li> <li>• Attendance in the groups was high.</li> <li>• The rooms and group arrangements were appropriate for the lessons of the day.</li> <li>• The Substance Abuse Recovery group process could have been</li> </ul>		

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		<p>improved with structure and "firmer" rules on behavior during group sessions.</p> <ul style="list-style-type: none"> <li>The Medication and Wellness group would have been more productive if the providers included individuals in the role-play sessions as well incorporated side effects of medication that the individuals were experiencing as opposed to those that were indicated in the medical literature.</li> </ul> <p>This monitor reviewed a sample of the Facilitator Mall Provider Observation Monitoring Form. All the forms had checked "yes" for all items. This monitor suspects that the auditors were "easy" on the facilitators to have given "yes" to all items in all observations. In addition, the audit forms did not have any documentation on what was observed, for example noting the type of instructional techniques utilized, the level of language used, and the level of language found in the handouts, etc. Auditors need to make such notations to be able to give credibility to their observations as well as to use the information to give feedback to facilitators where indicated.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH reported that all 112 Substance Abuse Recovery providers and co-providers are certified.</p>

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		<table border="1" data-bbox="968 228 1871 380"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>112</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>112</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>100%</td> </tr> </table> <p data-bbox="968 423 1892 824">Document review and staff information found that all Substance Abuse Recovery providers at MSH were trained and certified using the DMH Substance Abuse Curriculum. No updated training had been conducted during this review period. The facility has established a "Clinical Psychology Doctoral Practicum" with five doctoral candidates dedicated to the Substance Abuse Recovery Program. According to the Substance Abuse Recovery Services Coordinator, the facility plans on having the Substance Abuse Recovery Curriculum on the web for re-training and update training purposes. Fidelity checks had been conducted on a quarterly basis. The facility had also completed a Patient Satisfaction Survey.</p> <p data-bbox="968 867 1906 1305">This monitor observed two Substance Abuse Recovery Mall groups (SAR, for stages 1.2.3. and for stages 3.4.5). The facilitators of both groups had undergone training using the MSH Substance Abuse Recovery Curriculum. This monitor had to leave the SAR 1.2.3 group as one of the individual in the group was not agreeable to entertain visitors. In the SAR 3.4.5 group, the provider was competent in the course content. The lesson plan and topic was appropriate to the individuals' stages of learning and cognitive abilities. However, the Mall group process and procedures themselves could have been better in that the provider had difficulty managing some of the individuals who were "mischievous" with the facilitator due to lack of a proper boundary established by the provider, and the provider failed to use the individuals' life experiences and needs.</p> <p data-bbox="968 1349 1115 1414"><b>Compliance:</b> Substantial.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	112	Number of certified SAR providers/co-providers	112	Percentage of SAR providers/co-providers who are certified	100%
Number of Substance Abuse Recovery (SAR) providers/co-providers	112							
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																													
C.2.r	<p>Transportation and staffing issues do not preclude individuals from attending appointments.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to track reasons for cancellation, and correct high cancellations.</p> <p><b>Findings:</b> The facility provided the following data on scheduled and cancelled appointments:</p> <table border="1" data-bbox="968 673 1831 1101"> <thead> <tr> <th colspan="6">Missed Appointments Monitoring - Medical Services</th> </tr> <tr> <th></th> <th colspan="2">Appointments</th> <th colspan="3">Reasons for Cancellation</th> </tr> <tr> <th></th> <th>Sched- uled</th> <th>Cancelled</th> <th>Staffing</th> <th>Transpor- tation</th> <th>Other</th> </tr> </thead> <tbody> <tr> <td>Aug</td> <td>1643</td> <td>462</td> <td colspan="3" rowspan="7" style="text-align: center; vertical-align: middle;">No data provided</td> </tr> <tr> <td>Sep</td> <td>1609</td> <td>538</td> </tr> <tr> <td>Oct</td> <td>1791</td> <td>581</td> </tr> <tr> <td>Nov</td> <td>1445</td> <td>452</td> </tr> <tr> <td>Dec</td> <td>1489</td> <td>501</td> </tr> <tr> <td>Jan</td> <td>1645</td> <td>557</td> </tr> <tr> <td>Total</td> <td>9622</td> <td>3091</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>The table above also indicates that between 66% and 72% of scheduled appointments had been completed. According to the facility, the MSH Non-Adherence Protocol to address clinic refusals was implemented to address clinic refusals. Subsequent to the tour, the facility provided additional information confirming that no appointments were canceled due to staffing or transportation issues.</p>	Missed Appointments Monitoring - Medical Services							Appointments		Reasons for Cancellation				Sched- uled	Cancelled	Staffing	Transpor- tation	Other	Aug	1643	462	No data provided			Sep	1609	538	Oct	1791	581	Nov	1445	452	Dec	1489	501	Jan	1645	557	Total	9622	3091			
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 98%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs for 12 individuals found that 10 of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (DPP, HCR, JR, MC, MCF, NK, PB, SM, TC and VC). The remaining two (LJC and RR) did not assign individuals to appropriate groups corresponding to their diagnoses, needs, and/or cognitive levels, or the groups listed in the interventions were not listed in the individuals' Mall schedules.</p> <p><b>Other findings:</b> As the table below indicates, the number of individuals enrolled in Cognitive Remediation Groups has increased incrementally over the last few quarters:</p>

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		<table border="1" data-bbox="968 228 1801 531"> <thead> <tr> <th colspan="5">Individuals in need of Cognitive Remediation Groups during the current and previous three Mall terms</th> </tr> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sep 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>144</td> <td>129</td> <td>145</td> <td>132</td> </tr> <tr> <td>Receiving service</td> <td>53</td> <td>67</td> <td>90</td> <td>92</td> </tr> </tbody> </table> <p>MSH continues to increase the number of cognitive remediation and related groups, adding groups such as Cognitive Behavior Therapy (CBT) for fear and anxiety, CBT for psychosis, and Cognitive Rehabilitation 2. More cognitive remediation groups are needed, however, to provide service to all individuals with identified need.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Individuals in need of Cognitive Remediation Groups during the current and previous three Mall terms						Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	With identified need	144	129	145	132	Receiving service	53	67	90	92
Individuals in need of Cognitive Remediation Groups during the current and previous three Mall terms																						
	Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010																		
With identified need	144	129	145	132																		
Receiving service	53	67	90	92																		
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 96%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous</p>																				

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		<p>review period.</p> <p>A review of the WRPs for six individuals found that five of the WRPs met the elements of this requirement (DPP, HH, ML, PB and TC) and the remaining one (RR) was missing one or more elements or did not satisfy the criteria for this recommendation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																									
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need.</li> <li>• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</li> </ul> <p><b>Findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="968 1117 1875 1383"> <thead> <tr> <th colspan="5">Individuals in need of WRP Education during the current and previous three Fall terms</th> </tr> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sept 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>579</td> <td>557</td> <td>345</td> <td>325</td> </tr> <tr> <td>Receiving service</td> <td>579</td> <td>557</td> <td>295</td> <td>309</td> </tr> <tr> <td>% receiving service</td> <td>100%</td> <td>100%</td> <td>86%</td> <td>95%</td> </tr> </tbody> </table>	Individuals in need of WRP Education during the current and previous three Fall terms						Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010	Oct-Dec 2010	With identified need	579	557	345	325	Receiving service	579	557	295	309	% receiving service	100%	100%	86%	95%
Individuals in need of WRP Education during the current and previous three Fall terms																											
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		<table border="1" data-bbox="968 228 1850 573"> <thead> <tr> <th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (August 2010-January 2011)</th> </tr> </thead> <tbody> <tr> <td>Sessions scheduled</td> <td>2,048</td> </tr> <tr> <td>Sessions held</td> <td>1,680</td> </tr> <tr> <td>% held</td> <td>82%</td> </tr> <tr> <td>Individuals scheduled</td> <td>377</td> </tr> <tr> <td>Individuals attended at least one group per month</td> <td>341</td> </tr> <tr> <td>% attended</td> <td>90%</td> </tr> </tbody> </table> <p data-bbox="968 613 1864 756">As shown in the table above, MSH had enrolled 95% of the individuals in WRP education groups, an increase from 86% from the previous review period. Attendance has increased as well, to 90% from 80% during the previous review period.</p> <p data-bbox="968 800 1871 902">A review of the records of 11 individuals found that nine were enrolled in WRAP groups (APR, CAG, FC, JGH, JTK, MCL, MDS, MF and TG) and two were not (MM and SH).</p> <p data-bbox="968 946 1115 1013"><b>Compliance:</b> Substantial.</p> <p data-bbox="968 1057 1434 1123"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (August 2010-January 2011)		Sessions scheduled	2,048	Sessions held	1,680	% held	82%	Individuals scheduled	377	Individuals attended at least one group per month	341	% attended	90%
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C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p data-bbox="968 1170 1566 1200"><b>Current findings on previous recommendations:</b></p> <p data-bbox="968 1243 1549 1273"><b>Recommendations 1 and 2, September 2010:</b></p> <ul data-bbox="968 1284 1545 1351" style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure consistency of data across reviews.</li> </ul>														

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		<p><b>Findings:</b> The following is a summary of the facility's data:</p> <table border="1" data-bbox="968 305 1908 566"> <thead> <tr> <th colspan="5">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sep 2010</th> <th>Oct-Dec 2010</th> </tr> </thead> <tbody> <tr> <td># of individuals needing service</td> <td>364</td> <td>362</td> <td>652</td> <td>608</td> </tr> <tr> <td># of individuals receiving service</td> <td>364</td> <td>362</td> <td>599</td> <td>564</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Individuals Needing and Provided Medication Education Groups						Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	# of individuals needing service	364	362	652	608	# of individuals receiving service	364	362	599	564
Individuals Needing and Provided Medication Education Groups																						
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C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Implement a system of trigger notifications and tracking of response by the WRPTs.</p> <p><b>Findings:</b> MSH tracks and monitors non-adherence to Mall groups through the WRPTs and through the more recently established Quality Council. According to the Mall Director the Quality Council now has implemented the non-adherence protocol. However, there were no data to review from the established system or the WRPT's response. This monitor reviewed the MSH Non-Adherence Committee report. The following is a summary of the Committee's recommendations:</p> <ol style="list-style-type: none"> <li>1. Staff training in techniques and strategies to motivate individuals who</li> </ol>																				

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>are non-adherent, including Motivational Interviewing, Narrative Restructuring Therapy (MSH has had these activities conducted during this review period from multiple sources including their in-house experts and experts from Coalinga State Hospital, in February 2011).</p> <ol style="list-style-type: none"> <li>2. Open Focus 6 for individuals refusing to attend medical appointments due to non-motivational reasons.</li> <li>3. Address PSR Mall group non-attendance through a Focus to increase the individual's participation in treatment.</li> <li>4. Monitor Mall group facilitators to ensure they use appropriate strategies and materials to conduct their groups.</li> <li>5. Implement Cognitive Behavioral Therapy groups to address fears, phobias and psychosis.</li> </ol> <p>Future plans in addition to the above:</p> <ol style="list-style-type: none"> <li>1. Track non-adherence on a monthly basis to determine reasons for non-adherence and determine specific treatments on an individual basis.</li> <li>2. Examine and correct By Choice integrity of implementation.</li> <li>3. Continue to develop Cognitive Behavior Therapy and related groups as indicated by assessment data.</li> <li>4. Refer cases to PBS when deemed necessary for behavioral guidelines or Positive Behavior Support plans.</li> </ol> <p><b>Recommendation 2, September 2010:</b> Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.</p> <p><b>Findings:</b> As discussed in the recommendation above, the facility has conducted assessment and put forth plans to address this issue systematically. However, at this time, the facility did not present non-adherence data.</p>
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		<p><b>Recommendation 3, September 2010:</b>          Provide data regarding:</p> <ul style="list-style-type: none"> <li>a) All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers);</li> <li>b) The number of individuals receiving these interventions; and</li> <li>c) The number of individuals who trigger non-adherence to WRP in the key indicators.</li> </ul> <p><b>Findings:</b>          The facility did not present data addressing all requirements for the recommendations above. However, the facility presented data on NRT therapy for seven individuals (AL, CR, JD, KC, MB, MF and RM). Chart reviews found that interventions had been conducted for medical/clinical non-adherence, whereas non-adherence to Mall groups generally was discussed in the Present Status sections and in some cases statements that the individual "would be encouraged to attend" were documented. Such strategies would not be a match without first identifying the reasons for the individual's non-attendance at Mall groups. MSH should fully implement its plan immediately.</p> <p>According to the Mall Director, MSH has 25 trained staff in Motivational Interviewing, and three staff trained in Narrative Restructuring Therapy. The facility also uses Dialectical Behavior Therapy to address cancellation and refusal of medical appointments.</p> <p>This monitor reviewed records of nine individuals (BE, BMY, GS, JGH, MCM, MDS, SAM, TE and TG) who met Mall non-adherence threshold, refused medical/clinic appointments, or were noted to have poor Mall group attendance but did not yet meet the non-adherence threshold. In a number of cases, interventions were not implemented to address poor or non-adherence (BMY, JGH and MDS). In other cases, one or two strategies were being conducted to address poor Mall attendance or clinic</p>
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		<p>appointments. For example, WRPT decided to “continue to encourage” SAM to attend the Mall groups as well as keep scheduled clinic appointments; remind, discuss, encourage, support, and educate TE to keep dental appointments; and had opened a Focus 6 to address GS’s refusal to keep medical appointments using Motivational Interviewing as an intervention.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Implement a system of trigger notifications and tracking of response by the WRPTs.</li><li>2. Provide information to demonstrate that MSH’s current program to motivate individuals addresses barriers towards individuals’ participation in their WRPs, including Mall groups.</li><li>3. Provide data regarding:<ol style="list-style-type: none"><li>d) All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions that are provided (with number of providers);</li><li>e) The number of individuals receiving these interventions; and</li><li>f) The number of individuals who trigger non-adherence to WRP in the key indicators.</li></ol></li></ol>
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<b>D. Integrated Assessments</b>		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p><b>Summary of Progress on Psychiatric Assessments and Diagnoses:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained substantial compliance with all the requirements in section D.1., including further progress in the content of inter-unit transfer assessments.</li> <li>2. The new template for the streamlined comprehensive psychiatric assessment includes an excellent violence risk assessment tool including information on the specific type of aggression as well as synthesis of the risk assessment.</li> </ol> <p>In order to maintain substantial compliance in this section, the facility needs to ensure the following:</p> <ol style="list-style-type: none"> <li>1. Completion of the section of the comprehensive psychiatric assessment that provides a synthesis of the violence risk assessment; and</li> <li>2. That psychiatric reassessments are sufficiently individualized regarding the following:               <ol style="list-style-type: none"> <li>a. The review of the risks and benefits of treatment particularly for individuals who suffer from significant metabolic dysfunction and receive high-risk treatment; and</li> <li>b. Adequate synthesis of clinical developments during the interval.</li> </ol> </li> </ol> <p><b>Summary of Progress on Psychological Assessments:</b></p> <p>As of the March 2010 tour, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Nursing Assessments:</b></p> <p>MSH has continued to maintain substantial compliance with the</p>

		<p>requirements of Section D.3. The quality of MSH's admission and comprehensive (integrated) assessments remains exceptional.</p> <p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</li> <li>2. In order to maintain compliance in the future, IA:RTS objectives and interventions should not be limited to the areas of leisure and recreation (focus 10); therapists should consider the individual's comprehensive needs for discharge and recovery when writing initial RT objectives and interventions. Furthermore, the WRPT should utilize the comprehensive information found in the IA:RTS to optimally inform treatment planning.</li> <li>3. Review of revised IA:RTS found that the new format supported continued comprehensive findings yet in a more concise and clinically useful structure. MSH should work to update current RT focused assessments to improve their clinical utility and meaningfulness, while ensuring that they continue to meet EP requirements.</li> </ol> <p><b>Summary of Progress on Nutrition Assessments:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</li> <li>2. MSH continues to assign all individuals to an acuity level of III or IV; in order to maximize resources and focus on service provision, it may be necessary to reassess and/or conduct needs assessment and assessment of outcomes to support continuation of this practice.</li> <li>3. Clinicians are not consistently using Nutrition Care process guidelines</li> </ol>
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Section D: Integrated Assessments

		<p>(Problem-Etiology-Signs/Symptoms) for writing nutrition diagnoses. In order to maintain compliance in the future, this should be addressed as the Nutrition Care process is the standard of practice supported by the ADA.</p> <p>4. RD auditors are not consistently conducting live audits of charts, but are auditing hard or soft copies of assessments and WRP documents.</p> <p><b>Summary of Progress on Social History Assessments:</b> MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section will therefore cease per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on Court Assessments:</b> As of the tour conducted in March 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Michael Barsom, MD, Medical Director</li> <li>2. Nady Hanna, MD, Assistant Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 32 individuals: AB, AJG, AM, AMB, AMW, BE, BJ, BLW, BMY, CAG, CRA, DPP, EAO, FCR, FNK, GAB, GW, GWA, JJS, LJO, LMN, MG, MLC, MM, PJJ, RC, RCC, SAL, SD, TLH, WRM and ZC</li> <li>2. Monthly Psychiatrist Progress Note for 26 individuals; AS, CA, EA, GB, IB, JH, JHM, JM, JN, KS, LJO, MA, MG, MLM, MN, MS, PC, PD, SAE, SJC, SP, TD, TPB, VA, WHB and YK</li> <li>3. Comprehensive Psychiatric Assessments on the following six individuals: BF, CEH, CM, CW, DB and MM.</li> <li>4. DMH Medical Initial Admission Assessment Audit summary data (August - January 2010/2011)</li> <li>5. DMH Admission Psychiatric Assessment summary data (August - January 2010/2011)</li> <li>6. DMH Integrated Psychiatric Assessment Auditing summary data (August - January 2010/2011)</li> <li>7. DMH Weekly Physician Progress Note Audit summary data (August - January 2010/2011)</li> <li>8. DMH Monthly PPN Auditing summary data (August - January 2010/2011)</li> <li>9. DMH Physician Inter-Unit Transfer Note Audit summary data (August - January 2010/2011)</li> <li>10. Templates of the DMH Brief Admission Assessment: Psychiatry Section and DMH Comprehensive Psychiatric Assessment.</li> </ol>

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<p>D.1.a</p>	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders (“DSM”) for reaching the most accurate psychiatric diagnoses.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (August 2010 - January 2011). The average samples were 83% of admission assessments, 65% of integrated assessments and 23% of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 672 1890 750"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnosis is documented</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 899 1890 1127"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.</td> <td><i>Psychiatric history, including review of present and past history</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Current psychiatric diagnoses</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 1276 1890 1390"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.b</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i></td> <td>100%</td> </tr> </tbody> </table>	Admission Assessment			4.	<i>Admission diagnosis is documented</i>	100%	Integrated Assessment			2.	<i>Psychiatric history, including review of present and past history</i>	100%	7.	<i>Diagnostic formulation</i>	100%	8.	<i>Differential diagnosis</i>	100%	9.	<i>Current psychiatric diagnoses</i>	100%	Monthly PPN			3.b	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated</i>	100%
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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.						
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue current practice.</li> <li>• Continue to provide data regarding the number of FTE psychiatric positions (all positions and positions providing direct care) and number of board certified psychiatrists (average during the review period compared to previous review).</li> </ul> <p><b>Findings:</b> The facility reported that as of January 2011, 100% of the psychiatrists employed by MSH successfully completed at least three years of psychiatry residency training in a residency program that is accredited by the Accreditation Counsel for Graduate Medical Education (ACGME).</p> <p>The following table summarizes the number and type of positions:</p> <table border="1" data-bbox="991 1304 1816 1386"> <thead> <tr> <th>Positions</th> <th>July 2010</th> <th>Jan 2011</th> </tr> </thead> <tbody> <tr> <td>All FTE positions</td> <td>43</td> <td>46</td> </tr> </tbody> </table>	Positions	July 2010	Jan 2011	All FTE positions	43	46
Positions	July 2010	Jan 2011						
All FTE positions	43	46						

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		<table border="1" data-bbox="991 190 1816 321"> <tr> <td>FTE Positions providing direct care</td> <td>35</td> <td>38</td> </tr> <tr> <td>Board Certified Psychiatrists</td> <td>23</td> <td>25</td> </tr> <tr> <td>Board Eligible Psychiatrists</td> <td>23</td> <td>24</td> </tr> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice.</li> <li>2. Continue to provide data regarding the number of FTE psychiatric positions (all positions and positions providing direct care) and number of board certified psychiatrists (average during the review period compared to previous review).</li> </ol>	FTE Positions providing direct care	35	38	Board Certified Psychiatrists	23	25	Board Eligible Psychiatrists	23	24
FTE Positions providing direct care	35	38									
Board Certified Psychiatrists	23	25									
Board Eligible Psychiatrists	23	24									
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> During this review period, 20 psychiatrists were repriviledged using the current performance indicators, representing 100% of the psychiatrists who were scheduled for reprivileging per the facility's policy.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice.</li> <li>2. Continue to provide data on the number of psychiatrists who were repriviledged using the current performance indicators and their percentage of all psychiatrists who were scheduled for reprivileging as per the facility's policy.</li> </ol>									

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D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Admission Medical Assessment Monitoring Form, MSH assessed compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 88% of admissions each month during the review period (August 2010 - January 2011). The facility reported a mean compliance rate of 100% with the 24-hour requirement. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> A review of the charts of ten individuals (AJG, AMB, BE, CAG, CRA, GW, MM, SAL, WRM and ZC) found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.c.i.1	a review of systems;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.2	medical history;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.i.3	physical examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.4	diagnostic impressions; and	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.i.5	management of acute medical conditions	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Admission Psychiatric Assessment Audit, MSH reported a compliance rate of 100% based on an average sample of 83% of admissions each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> During this review period, the facility transitioned from the system of Admission Psychiatric Assessment and Integrated Psychiatric Assessment to a newer and more streamlined system of Brief (Admission) Psychiatric Assessment and Comprehensive (Integrated) Psychiatric Assessment. The new templates adequately addressed requirements of the EP regarding, including a brief risk assessment as part of the Brief Psychiatric Assessment and a more detailed risk assessment as part of</p>

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		<p>the Comprehensive Psychiatric Assessment. The detailed risk assessment included an improved violence risk assessment that provided more information regarding the type of aggression (psychotic, impulsive and/or predatory) and an overall synthesis of information regarding the risk assessment.</p> <p>The monitor reviewed the charts of 15 individuals, including ten individuals whose assessments were completed using the new Brief Psychiatric Assessment template (AJG, AMB, BD, BF, CEH, CM, CW, GW, MM and ZC) and five individuals whose assessments were completed using the older template (BE, CAG, CRA, SAL and WRM). This review found substantial compliance in nine charts (BD, BF, CEH, CM, CRA, CW, SAL, WRM and ZC) and partial compliance in six charts (AJG, AMB, BE, CAG, GW and MM). The charts of BE, CAG and MM included inadequate plans of care. During the transition to the new system, there was a brief time gap between implementation of the Brief Psychiatric Assessment and the corresponding Comprehensive Psychiatric Assessment. As a result of this, the charts of AJG, AMB, GW and MM did not include the detailed violence risk assessment.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.2	complete mental status examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that MSH has maintained a compliance

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		rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.6	consultations ordered; and	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Psychiatry Section Audit, MSH reported a compliance rate of 100% based on an average sample of 65% of Integrated Assessments due each month during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p><b>Other findings:</b> The monitor reviewed the charts of the above-mentioned 15 individuals</p>

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		<p>and found substantial compliance in 14 charts and partial compliance in one (AJG). It was noted that the practitioners often did not complete the section that provides a synthesis of the violence risk assessment</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure completion of the section that provides synthesis of the violence risk assessment.</li> </ol>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 6	diagnostic formulation;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 7	differential diagnosis;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.																
D.1.c.iii. 9	psychopharmacology treatment plan; and	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.																
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.																
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.																
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Provide documentation of continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p><b>Findings:</b> The following outlines CME activities during this review period. These activities were well aligned with the current needs of the facility.</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/ affiliations</th> <th>Attendees</th> </tr> </thead> <tbody> <tr> <td>8/10/10</td> <td>Efficacy and Tolerability of Asenapine in acute Schizophrenia</td> <td>Steven G. Potkin, MD UC Irvine</td> <td>24</td> </tr> <tr> <td>8/11/10</td> <td>Hyperprolactinemia</td> <td>Behnam Behnam, MD, MSH</td> <td>15</td> </tr> <tr> <td>8/12/10</td> <td>The Importance of Effective Treatment in</td> <td>Robert M. McCarren, DO, UC</td> <td>13</td> </tr> </tbody> </table>	Date	Title	Speaker/ affiliations	Attendees	8/10/10	Efficacy and Tolerability of Asenapine in acute Schizophrenia	Steven G. Potkin, MD UC Irvine	24	8/11/10	Hyperprolactinemia	Behnam Behnam, MD, MSH	15	8/12/10	The Importance of Effective Treatment in	Robert M. McCarren, DO, UC	13
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			Schizophrenia	Davis	
		8/17/10	Adjunctive Therapy of Current Antidepressants Treatment in MDD	Jim Bratty, MD, UCLA	16
		8/18/10	Forensic Updates	David Niz, MD, UCLA	23
		9/9/10	Effective Treatment in Schizophrenia	Rimal B. Bera, MD, UC Irvine	03
		9/14/10	Rethinking Schizophrenia Management: Exploring a Once-Monthly medication	Jonathan Meyer, MD, UC San Diego	14
		9/15/10	Treatment Resistant Schizophrenia	Rimel Bera, MD UC Irvine	18
		9/29/10	Categorization of Aggressive Acts Committed by Chronically Assaultive State Hospital Patients	Rupali Chadha, MD, MSH	20
		10/5/10	Current Updates in the Treatment of Mood Disorders	Gerald Maguire, MD, UC Irvine	12
		10/13/10	Sepsis	Zakaria Boshra, MD, King/Charles R. Drew School of Medicine	13
		10/14/10	Treatment Decision in Schizophrenia	Alejandro Alva, MD, ATP Clinical research	15
		10/19/10	Balance of Efficacy and Safety in the Acute Treatment of Bipolar I	S. Craig Risch, MD, UC San Francisco	11

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			Mania and Schizophrenia	
	10/20/10	Metabolic Effects of New Antipsychotic Medications	Gerald Maguire, MD, UC Irvine	25
	10/21/10	The Importance of Effective Treatment in Schizophrenia	Jody Ryan, MD, Denver Community Mental Health	15
	10/28/10	The importance of early Treatment Response on Schizophrenia	David Naimark, MD, UC San Diego	18
	11/2/10	Balance of Efficacy and Safety in the Acute Treatment of Bipolar I Mania and Schizophrenia	Thomas Grayden, MD, UC Irvine	15
	11/3/10	Atypical Antipsychotics	Steven Stahl, MD, Video Conference, moderated by Michael Cummings, MD, PSH	3
	11/4/10	The Role of Once-monthly Therapy in the Treatment of Schizophrenia	Weiguo Zhu, MD, PhD, USC Keck School of Medicine	19
	11/9/10	New Treatment option for Adjunctive Therapy to Antidepressants	Alejandro Alva, MD, Chapman Medical Center	12
	11/17/10	Atypical Antipsychotics	Darin Signorellis, MD, USC	27
	12/2/10	A Look at a New Treatment Option for	Jason Kellogg, MD, ATP Clinical	16

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			Adjunctive Therapy to Antidepressants for Major Depressive Disorder.	Research	
		12/8/10	Informed Consent	David Niz, MD, UCLA	20
		12/14/10	Balance of Efficacy and Safety in the Acute Treatment of Bipolar I Mania and Schizophrenia	Daniel Susuki, MD, USC	19
		12/5/10	The Role of Long Acting Olanzapine	Tara Yuan, MD, Private Practice	8
		1/19/11	New Advances in the Long Acting Injectable Treatment of Schizophrenia	Gerald Maguire, MD, UC Irvine	8
		1/19/11	Pancreatitis Updates Video Conference via Patton State Hospital	Behnam Behnam, MD, MSH	4
		1/26/11	Depression in Older Adults	Ira Lesser, MD, UCLA	30
		<p><b>Recommendation 2, September 2010:</b> Provide comparative data regarding the average number of individuals who have had diagnoses listed as Deferred, NOS and/or R/O for two or more months during the review period compared with the last period.</p> <p><b>Findings:</b> The facility provided the following data:</p>			

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Diagnostic category	Previous Period	Current Period
	Number of individuals in category regardless of duration	
Rule Out	29	19
Deferred	10	8
NOS	30	25
	Number of individual in category who received treatment for more than 60 days	
Rule Out	3	2
Deferred	7	1
NOS	13	2

**Other findings:**  
 At the time of this review, only two individuals received NOS diagnoses for more than 60 days. Both individuals were diagnosed with Cognitive Disorder NOS. The review found substantial compliance in the chart of NTM and partial compliance in the chart of EAO (due to inadequate justification for "Chronic Delirium").

**Compliance:**  
 Substantial.

**Current recommendations:**

1. Provide documentation of continuing medical education (CME) to psychiatry staff including the title of each program, the speakers and affiliation and the number and disciplines of attendees.
2. Consider CME activity to address the potential benefits of beta blocker agents in the management of individuals with aggressive/explosive behavior.
3. Consider CME activity (for both nursing and medical staff) dedicated to understanding and management of delirium.
4. Provide comparative data regarding the average number of individuals

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		<p>who have had diagnoses listed as Deferred, NOS and/or R/O for two or more months during the review period compared with the last period.</p>
D.1.d.ii	<p>The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in D.1.a.</p> <p><b>Findings:</b> Same as in D.1.a.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in D.1.a.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in D.1.d.i.</p> <p><b>Findings:</b> Same as in D.1.d.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Same as in D.1.d.i.</p>

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<p>D.1.d.iv</p>	<p>"no diagnosis" is clinically justified and documented.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to provide information regarding the number of individuals who have received "No Diagnosis" on Axis I (during this reporting period), review of justification and results of this review.</p> <p><b>Findings:</b> The facility reported that no individual received "no diagnosis" on Axis I during this review period.</p> <p><b>Other findings:</b> This monitor found no evidence of this diagnosis during chart reviews.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to provide information regarding the number of individuals who have received "No Diagnosis" on Axis I (during the review period), review of justification and results of this review.</p>
<p>D.1.e</p>	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Weekly Physician Progress Note (PPN) Audit, MSH reported a compliance rate of 100% based on an average sample of 34% of individuals with length of stay less than 60 days during the review period (August 2010 - January 2011). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous</p>

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		<p>review period.</p> <p>MSH also used the DMH Monthly PPN Audit to assess compliance, reporting a compliance rate of 100% based on an average sample of 23% of individuals who had been hospitalized for 90 days or more. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> The monitor reviewed the charts of ten individuals (AJG, AMB, BE, CAG, CRA, GW, MM, SAL, WRM and ZC) who were admitted during this review period and found compliance in all cases regarding the frequency of weekly notes for individuals hospitalized fewer than 60 days. A review of the charts of 10 individuals hospitalized for 90 or more days (AB, BJ, DPP, GAB, GWA, LMN, MG, MLC, RC and TLH) found compliance in all cases</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Address and correct this monitor's findings of some deficiencies regarding the use of PRN/Stat medications.</li> </ul> <p><b>Findings:</b> MSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample was 23% of individuals who had been hospitalized for 90</p>

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		<p>days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p><b>Recommendation 3, September 2010:</b> Streamline current templates for documentation of psychiatric reassessments to improve attention to relevant clinical data.</p> <p><b>Findings:</b> MSH did not respond to this recommendation.</p> <p><b>Other findings:</b> This monitor reviewed Monthly Psychiatrist Progress Note for 26 individuals: AS, CA, EA, GB, IB, JH, JHM, JM, JN, KS, LJO, MA, MG, MLM, MN, MS, PC, PD, SAE, SJC, SP, TD, TPB, VA, WHB, and YK.</p> <p>The review found general evidence of substantial compliance with this requirement. However, the psychiatric reassessments often emphasized generic risks of treatment at the expense of actual side effects. In general, the risks and benefits of treatment were not sufficiently individualized, particularly for individuals who suffer from significant metabolic dysfunction and receive high-risk treatment, and the clinical developments during the interval were listed without adequate synthesis of the significance of these events.</p> <p>This monitor reviewed the charts of six individuals who received PRN and/or Stat medications prior to the use of seclusion/restraints during this review period. The following table outlines these reviews:</p> <table border="1" data-bbox="991 1226 1906 1414"> <thead> <tr> <th>Initials</th> <th>PRN/Stat Medications ordered</th> <th>Date of administration</th> </tr> </thead> <tbody> <tr> <td>BMY</td> <td>Lorazepam, haloperidol and diphenhydramine (PRN)</td> <td>1/21/11</td> </tr> <tr> <td>FCR</td> <td>Lorazepam, haloperidol and</td> <td>12/3/10</td> </tr> </tbody> </table>	Initials	PRN/Stat Medications ordered	Date of administration	BMY	Lorazepam, haloperidol and diphenhydramine (PRN)	1/21/11	FCR	Lorazepam, haloperidol and	12/3/10
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FCR	Lorazepam, haloperidol and	12/3/10									

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			diphenhydramine (Stat)	
		FNK	Risperidone (PRN)	11/4/10
		JJS	Lorazepam, haloperidol and diphenhydramine (Stat)	1/11/11
		JJS	Olanzapine (PRN)	1/11/11
		LJO	Lorazepam, chlorpromazine ad diphenhydramine (Stat)	12/4/10 and 12/6/10
		RCC	Lorazepam and haloperidol	12/3/10
		<p>This review is also relevant to the requirements in D.1.f.vi and F.1.b.</p> <p>In general, the review found that the facility had adequate practice in the following areas:</p> <ol style="list-style-type: none"> <li>1. Adjustment of regular medication regimen (and of PRN/Stat medication regimen) based on the review of PRN/Stat medication use; and</li> <li>2. Documentation of face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure that the psychiatric reassessments are sufficiently individualized regarding the following:             <ol style="list-style-type: none"> <li>a. The review of the risks and benefits of treatment, particularly for individuals who suffer from significant metabolic dysfunction and receive high-risk treatment; and</li> <li>b. Adequate synthesis of clinical developments during the interval.</li> </ol> </li> </ol>		

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D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.				
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.				
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1" data-bbox="991 492 1795 716"> <tr> <td data-bbox="991 492 1087 716">5.</td> <td data-bbox="1087 492 1795 716"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td data-bbox="1795 492 1892 716">100%</td> </tr> </table>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	100%	<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	100%				
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.				
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.				
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.				

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	<p>psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and</p>							
<p>D.1.f.vii</p>	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<p>100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>						
<p>D.1.g</p>	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Address and correct this monitor's findings of some deficiencies in the documentation of the assessments.</li> </ul> <p><b>Findings:</b> MSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 47% of the individuals who experienced inter-unit transfer per month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1304 1887 1416"> <tr> <td data-bbox="991 1304 1087 1377">1.</td> <td data-bbox="1087 1304 1793 1377"><i>Psychiatric course of hospitalization, including medication trials</i></td> <td data-bbox="1793 1304 1887 1377">100%</td> </tr> <tr> <td data-bbox="991 1377 1087 1416">2.</td> <td data-bbox="1087 1377 1793 1416"><i>Medical course of hospitalization,</i></td> <td data-bbox="1793 1377 1887 1416">100%</td> </tr> </table>	1.	<i>Psychiatric course of hospitalization, including medication trials</i>	100%	2.	<i>Medical course of hospitalization,</i>	100%
1.	<i>Psychiatric course of hospitalization, including medication trials</i>	100%						
2.	<i>Medical course of hospitalization,</i>	100%						

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		<table border="1"> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>100%</td> </tr> </table>	3.	<i>Current target symptoms,</i>	100%	4.	<i>Psychiatric risk assessment,</i>	100%	5.	<i>Current barriers to discharge,</i>	100%	6.	<i>Anticipated benefits of transfer.</i>	100%	
3.	<i>Current target symptoms,</i>	100%													
4.	<i>Psychiatric risk assessment,</i>	100%													
5.	<i>Current barriers to discharge,</i>	100%													
6.	<i>Anticipated benefits of transfer.</i>	100%													
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b> A review of the charts of eight individuals who experienced inter-unit transfers during the review period found substantial compliance in seven cases (AM, AMW, CRA, FNK, PJJ, SD and WLB) and partial compliance in one (SAL).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>													

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2. Psychological Assessments		
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	As of March 2010, MSH had maintained substantial compliance with the requirements of Section D.2 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section has ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with	

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	generally accepted professional standards of care, shall:	
D.2.d.i	expressly state the clinical question(s) for the assessment;	
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	
D.2.d.iv	be based on current, accurate, and complete data;	
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	
D.2.d.vi	include the implications of the findings for interventions;	
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	
D.2.d.	Use assessment tools and techniques	

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viii	appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:	
D.2.f.i	before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:	
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric	

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	diagnosis; and	
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	
D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	

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3. Nursing Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Aubri Griffis, Nursing Coordinator, CNS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Nursing Admission Assessment data summary data, August 2010 - January 2011</li> <li>2. MSH Nursing Integrated Assessment Monitoring Audit summary data, August 2010 - January 2011</li> <li>3. MSH's training rosters</li> <li>4. Admission and integrated assessments and WRPs for the following 40 individuals: AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB</li> </ol>
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p><b>Compliance:</b> Substantial.</p>
D.3.a.i	a description of presenting conditions;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each</p>

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		<p>month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that MSH has maintained the excellent quality of the assessments and all 40 were found to be in substantial compliance. These findings comport with MSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 820 1890 971"> <tr> <td data-bbox="991 820 1087 971">1.</td> <td data-bbox="1087 820 1795 971"><i>The Present Status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1795 820 1890 971">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that MSH has also maintained the quality of the integrated assessments and all were found to be in substantial compliance. These findings comport with MSH's data.</p>	1.	<i>The Present Status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	100%
1.	<i>The Present Status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	100%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>2.</td> <td><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>2.</td> <td><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	100%						
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	100%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <p>MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>						

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		<p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.iv	allergies;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.v	pain;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least</p>

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		90% from the previous review period.
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 99%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>
D.3.a.ix	conditions needing immediate nursing interventions.	<p><u>Admission Assessments</u> MSH reported a mean compliance rate of 100%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u> MSH reported a mean compliance rate of 98%. Comparative data indicated that the facility has maintained a compliance rate of at least 90% from the previous review period.</p>

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<p>D.3.b</p>	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's Central Nursing Services Department's policy and procedures demonstrate that they are consistently using the Wellness and Recovery model for nursing.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>D.3.c</p>	<p>Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH training rosters verified that all of the RNs that were required to complete competency-based training regarding Nursing Assessments completed and passed the training and all had current California licenses.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	Please see sub-cells for compliance findings.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, MSH assessed its compliance based on a 100% sample of admissions each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that all were timely completed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Update the instructions for the assessment to reflect the seven-day</p>

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		<p>time frame (rather than the fourth or fifth day after admission).</p> <p><b>Findings:</b> MSH did not address this recommendation.</p> <p><b>Recommendation 2, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Integrated Assessment Monitoring Audit, MSH assessed its compliance based on a 100% mean sample of admissions each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 91%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that all were timely completed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that an RN attends the WRPCs for presentation of nursing assessment.</li> </ul>

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	<p>shall be the annual review.</p>	<ul style="list-style-type: none"> <li>• Ensure the attendance of PTs is documented in the WRPCs.</li> </ul> <p><b>Findings:</b> MSH reported that the enduring Psychiatric Technician and RN attending the WRPCs were not consistently signing the signature page upon finalizing the WRP. Beginning in August 2010, the facility began to audit the signature page of the WRPs to ensure all participants had signed, indicating their presence.</p> <p><b>Recommendation 3, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on a mean sample of 17% of WRPCs observed each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 820 1915 974"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>95%</td> <td>99%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>82%</td> <td>94%</td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (AG, AH, ANH, ARC, AV, BJW, CAH, CC, CTC, DEK, DEM, DM, GA, GAR, GRJ, HL, JAS, JDJ, JL, JNA, JS, JSS, JWP, MH, MLC, MLK, NR, PLB, RAG, RG, RLV, RLW, SAM, SDK, TE, TJM, TLP, TOM, TT and VRB) found that an RN attended the WRPC in 37 cases and a PT attended the WRPC in 38 cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	95%	99%	<i>Psychiatric Technician attendance at WRPC</i>	82%	94%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	95%	99%									
<i>Psychiatric Technician attendance at WRPC</i>	82%	94%									

4. Rehabilitation Therapy Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrea Cirola, Assistant Chief of Rehabilitation Therapy</li> <li>2. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>3. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>4. Rebecca McClary, Acting Supervising Rehabilitation Therapist</li> <li>5. Renee Kelly, Chief of Rehabilitation Therapy</li> <li>6. Ruth N. Flores, Supervisor for Vocational Services</li> <li>7. Terez Henson, Supervising Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. List of individuals who had IA:RTS assessments from August 2010 - January 2011</li> <li>2. Records of the following 12 individuals who had IA:RTS assessments from August 2010 - January 2011: BS, CB, DA, DLK, JLR, JPE, KMS, LS, MT, SL, TM and ZC</li> <li>3. List of individuals who had Occupational Therapy assessments from August 2010 - January 2011</li> <li>4. Records of the following four individuals who had Occupational Therapy assessments from August 2010 - January 2011: BE, JR, LB and MH</li> <li>5. List of individuals who had Physical Therapy assessments from August 2010 - January 2011</li> <li>6. Records of the following four individuals who had Physical Therapy assessments from August 2010 - January 2011: AV, EFL, MR and TW</li> <li>7. List of individuals who had Speech Therapy assessments from August 2010 - January 2011</li> <li>8. Records of the following five individuals who had Speech Therapy assessments from August 2010 - January 2011: DC, JDF, MCT, MD and REB</li> <li>9. List of individuals who had Vocational Rehabilitation assessments</li> </ol>

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		<p>from August 2010 - January 2011</p> <p>10. Records of the following five individuals who had Vocational Rehabilitation assessments from August 2010 - January 2011: BRL, IB, JEL, JLS and KR</p> <p>11. List of individuals who had CIPRTA assessments from August 2010 - January 2011</p> <p>12. Records of the following individual who had CIPRTA assessment from August 2010 - January 2011: LT</p> <p>13. POST referral form</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b>          During the maintenance period, implement the POST referral form to ensure that treatment teams are referring individuals for the most clinically appropriate and timely POST assessment services.</p> <p><b>Findings:</b>          The POST Referral form was implemented on 12/01/2010. In addition to the implementation of the POST Referral form, Supervising Rehabilitation Therapists began in October 2010 to attend weekly PRC meetings, as well as FRC and ETRC meetings, and to review daily HSS reports. This will allow for timely identification of need for POST focused assessments due to triggers, change in function, or change in high-risk status.</p> <p><b>Other findings:</b>          Review of revised IA:RTS found that the new format supported continued comprehensive findings yet in a more concise and clinically useful structure. Focused assessment tools should be revised, updated, and streamlined based on review and analysis of audit data, clinician recommendations for improving clinical utility, and changes in systemic needs and evolving standards of practice.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue efforts to improve and enhance current system and practice.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness (seven calendar days from admission) based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2010 - January 2011 (total of 240), and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness (fourteen days from referral) based on an average sample of 75% of Occupational Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 24 out of 32), and reported a mean compliance rate of 98%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>

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		<p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 41 out of 45), and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 53% of Speech Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 18 out of 34), and reported a mean compliance rate of 81%.</p> <p>Comparative data indicated a decline in compliance from 100% in the previous review period. The facility reported that the reduction in compliance is due to the Speech Therapist reducing his hours from full-time to part-time status.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found two records in compliance (DC and MCT), and three records not in compliance (JDF, MD and REB).</p>
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		<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness (30 days from referral) based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2010 - January 2011 (total of 80 out of 95), and reported a mean compliance rate of 97%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness (14 days from referral) based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2010 - January 2011 (total of two), and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessment with timeliness found the record in compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<b>Current findings on previous recommendation:</b>

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		<p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2010 - January 2011 (total of 240), and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 75% of Occupational Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 24 out of 32), and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 41 out of 45), and reported a mean compliance rate of 100%. Comparative data</p>
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		<p>indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 53% of Speech Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 18 out of 34), and reported a mean compliance rate of 90%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2010 - January 2011 (total of 80 out of 95), and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i</p>
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		<p>criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2010 - January 2011 (total of two), and reported a mean compliance rate of 90%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of one individual to assess compliance of CIPRTA assessment with D.4.b.i criteria found the record in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> During the maintenance period, continue efforts to ensure that assessments provide a meaningful comprehensive overview of each individual's functional status in order to inform optimal treatment planning.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2010 - January 2011 (total of 240):</p> <table border="1" data-bbox="991 1339 1890 1414"> <tr> <td data-bbox="991 1339 1087 1414">3.</td> <td data-bbox="1087 1339 1774 1414"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 1339 1890 1414">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%
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Section D: Integrated Assessments

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<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 75% of Occupational Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 24 out of 32):</p>		<table border="1"> <tr> <td data-bbox="978 779 1083 860">3.</td> <td data-bbox="1083 779 1776 860"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 779 1890 860">100%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	
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<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 41 out of 45):</p>						

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="978 186 1087 264">3.</td> <td data-bbox="1087 186 1776 264"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 186 1923 264">100%</td> </tr> <tr> <td data-bbox="978 264 1087 342">4.</td> <td data-bbox="1087 264 1776 342"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 264 1923 342">98%</td> </tr> </table>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	98%
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<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 53% of Speech Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 18 out of 34):</p>								
<table border="1"> <tr> <td data-bbox="978 821 1087 899">3.</td> <td data-bbox="1087 821 1776 899"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 821 1923 899">100%</td> </tr> <tr> <td data-bbox="978 899 1087 977">4.</td> <td data-bbox="1087 899 1776 977"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 899 1923 977">90%</td> </tr> </table>			3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	90%
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<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2010 - January 2011 (total</p>								

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		<p>of 80 out of 95):</p> <table border="1" data-bbox="991 264 1890 417"> <tr> <td data-bbox="991 264 1087 339">3.</td> <td data-bbox="1087 264 1776 339"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 264 1890 339">100%</td> </tr> <tr> <td data-bbox="991 339 1087 417">4.</td> <td data-bbox="1087 339 1776 417"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 339 1890 417">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period August 2010 - January 2011 (total of two):</p> <table border="1" data-bbox="991 933 1890 1086"> <tr> <td data-bbox="991 933 1087 1008">3.</td> <td data-bbox="1087 933 1776 1008"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 933 1890 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1087 1086">4.</td> <td data-bbox="1087 1008 1776 1086"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 1008 1890 1086">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessment with D.4.b.ii criteria found the record in substantial compliance.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period August 2010 - January 2011 (total of 240):</p> <table border="1" data-bbox="991 857 1890 974"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of 12 individuals to assess compliance of IA:RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 75% of Occupational Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
5.	<i>Identifies the individual's life goals,</i>	100%									
6.	<i>Strengths, and</i>	100%									
7.	<i>Motivation for engaging in wellness activities.</i>	100%									

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		<p>of 24 out of 32):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of four individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 91% of Physical Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 41 out of 45):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of four individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 53% of Speech Therapy Focused Assessments due each month for the review period August 2010 - January 2011 (total of 18 out of 34):</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	97%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	98%	7.	<i>Motivation for engaging in wellness activities.</i>	98%
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Section D: Integrated Assessments

		<table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>82%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>89%</td> </tr> </table> <p>Comparative data indicated that compliance rate for items 6 and 7 declined from last reporting period, when self-assessment data indicated that SLP focused assessments were 100% in compliance.</p> <p>A review of the records of five individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 84% of Vocational Rehabilitation Focused Assessments due each month for the review period August 2010 - January 2011 (total of 80 out of 95):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>95%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of five individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	82%	7.	<i>Motivation for engaging in wellness activities.</i>	89%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	95%
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7.	<i>Motivation for engaging in wellness activities.</i>	95%																		

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		<p>each month for the review period August 2010 - January 2011 (total of 2):</p> <table border="1" data-bbox="991 303 1892 418"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the record of one individual to assess compliance of CIPRTA assessment with D.4.b.iii criteria found the record in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
5.	<i>Identifies the individual's life goals,</i>	100%									
6.	<i>Strengths, and</i>	100%									
7.	<i>Motivation for engaging in wellness activities.</i>	100%									
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> The facility reported that one occupational therapist required training on the CIPRTA focused assessment and was trained to competency on 9/9/10; one vocational service supervisor required training on the vocational service screening tool, VRAT, and vocational service progress note and was trained to competency on 9/14/10; one vocational service supervisor required training on the Rehabilitation Therapy manual and was trained to competency on 9/17/10; and one vocational service supervisor</p>									

Section D: Integrated Assessments

		<p>required training on <i>CASAS</i> testing overview and was trained to competency on 10/13/10.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.4.d	<p>Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in D.4.b and sub-cells above.</p>	<p>All conversion assessments were completed as of January 2009.</p> <p><b>Compliance:</b> Substantial.</p>

Section D: Integrated Assessments

5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Denise Manos, Director of Nutrition Services</li> <li>2. Mary Ramirez, Assistant Director of Nutrition Services (Food Production)</li> <li>3. Portia Salvacion, Assistant Director of Nutrition Services (Clinical)</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Nutrition Care Monitoring audit data for August 2010 - January 2011 for each assessment type</li> <li>2. Lists of individuals with Nutrition Care Assessments due from August 2010 - January 2011 for each assessment type</li> <li>3. Records of the following eight individuals with type D.5.a assessments from August 2010 - January 2011: EA, GA, JJ, LEP, LH, SL, SM and TDR</li> <li>4. Records of the following three individuals with type D.5.c assessments from August 2010 - January 2011: BE, JP and TW</li> <li>5. Records of the following five individuals with type D.5.d assessments from August 2010 - January 2011: AH, AMM, CAL, IB and JLR</li> <li>6. Records of the following six individuals with type D.5.e assessments from August 2010 - January 2011: AG, CA, FPR, GB, LMA and SDK</li> <li>7. Records of the following four individuals with type D.5.g assessments from August 2010 - January 2011: CBB, CDS, DH and DM</li> <li>8. Records of the following seven individuals with type D.5.i assessments from August 2010 - January 2011: AIZ, CBS, CMG, FDPA, GCB, LH and OAR</li> <li>9. Records of the following four individuals with type D.5.j.i assessments from August 2010 - January 2011: GB, LT, MO and SCG</li> <li>10. Records of the following five individuals with type D.5.j.ii assessments from August 2010 - January 2011: AZ, CFR, JS, SR and SSG</li> </ol>

Section D: Integrated Assessments

<p>D.5.a</p>	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a assessments due each month for the review period August 2010 - January 2011 (total of 21):</p> <table border="1" data-bbox="991 597 1885 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>91%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	91%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	99%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 188 1887 418"> <tr> <td data-bbox="991 188 1087 264">14.</td> <td data-bbox="1087 188 1766 264"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1766 188 1887 264">100%</td> </tr> <tr> <td data-bbox="991 264 1087 305">15.</td> <td data-bbox="1087 264 1766 305"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1766 264 1887 305">100%</td> </tr> <tr> <td data-bbox="991 305 1087 345">16.</td> <td data-bbox="1087 305 1766 345"><i>Assessment is concise</i></td> <td data-bbox="1766 305 1887 345">100%</td> </tr> <tr> <td data-bbox="991 345 1087 386">17.</td> <td data-bbox="1087 345 1766 386"><i>Assessment is legible</i></td> <td data-bbox="1766 345 1887 386">100%</td> </tr> <tr> <td data-bbox="991 386 1087 418">18.</td> <td data-bbox="1087 386 1766 418"><i>Each page of the assessment is signed</i></td> <td data-bbox="1766 386 1887 418">100%</td> </tr> </table> <p data-bbox="991 464 1900 529">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 574 1900 639">A review of the records of eight individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.</p> <p data-bbox="991 685 1140 750"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 795 1457 860"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%															
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	Not applicable—MSH does not have a medical/surgical unit.															
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p data-bbox="991 1094 1591 1127"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1172 1457 1237"><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p data-bbox="991 1282 1881 1414"><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.c assessments due each month for the review period August 2010 -</p>															

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		<p>January 2011 (total of three):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at</p>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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		<p>least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of three individuals to assess compliance with Nutrition type D.5.a criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																		
D.5.d	<p>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 70% of Nutrition Type D.5.d assessments due each month for the review period August 2010 - January 2011 (total of 58 out of 83):</p> <table border="1" data-bbox="991 1044 1887 1414"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%
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D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission	<b>Current findings on previous recommendation:</b>																																				

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	<p>Nutrition Assessment will be completed within 7 days of admission.</p>	<p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 59% of Nutrition Type D.5.e assessments due each month for the review period August 2010 - January 2011 (total of 69 out of 117):</p> <table border="1" data-bbox="991 524 1890 1354"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	<p data-bbox="989 906 1577 938"><b>Current findings on previous recommendation:</b></p> <p data-bbox="989 980 1457 1045"><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p data-bbox="989 1088 1839 1195"><b>Findings:</b> The facility reported that no type D.5.f Nutrition assessments were indicated or completed during the review period.</p> <p data-bbox="989 1237 1908 1383"><b>Compliance:</b> Unable to determine; the facility had been in substantial compliance with this requirement during the four most recent review periods in which this type of assessment was performed.</p>															

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																				
D.5.g	<p>For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.g assessments due each month for the review period August 2010 - January 2011 (total of 29):</p> <table border="1" data-bbox="991 711 1885 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	98%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	100%
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D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 32% of Nutrition assessments (all types) due each month of the review period August 2010 - January 2011 (72 out of 222). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned</p>																					

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		<p>NST level.</p> <p>A review of the records of 45 individuals found that all had evidence of a correctly assigned Nutritional Status Type according to hospital protocol and all were in compliance with D.5.h.</p> <p><b>Other findings:</b> MSH has continued to assign all individuals to higher acuity levels of III or IV, requiring monthly or quarterly assessment updates. The rationale behind this practice is that it will allow clinicians to provide a proactive approach. However, due to the proactive nature of the risk management system, process for nutrition referral, and review of individuals with significant weight changes, it may be beneficial for the clinicians to reassess the need for this process, and utilize all acuity levels based on recommended criteria.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 18% of Nutrition Type D.5.i assessments due each month for the review period August 2010 - January 2011 (total of 26 out of 146):</p>

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		1.	<i>Assessment is completed on time per policy</i>	100%
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		18.	<i>Each page of the assessment is signed</i>	99%
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>				

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		<p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																								
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.j.i assessments due each month for the review period August 2010 - January 2011 (total of 26):</p> <table border="1" data-bbox="991 932 1890 1417"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>94%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>99%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	94%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	99%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	100%
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Section D: Integrated Assessments

		<table border="1"> <tr> <td></td> <td><i>identified</i></td> <td></td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>98%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Assessment is legible</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Each page of the assessment is signed</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of four individuals to assess compliance with Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>identified</i>		9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	98%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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D.5.j.ii	Every individual will be assessed annually.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p>																																	

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		<p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 39% of Nutrition Type D.5.j.ii assessments due each month for the review period August 2010 - January 2011 (total of 75 out of 192):</p> <table border="1"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> <tr> <td>14.</td> <td><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Assessment is concise</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%
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		17. <i>Assessment is legible</i>	100%
		18. <i>Each page of the assessment is signed</i>	100%
		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of five individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	

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6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donnie Yoo, LCSW, Supervising Social Worker</li> <li>2. James Park, LCSW, Supervising Social Worker</li> <li>3. Maribel Forbes, LCSW, Supervising Social Worker</li> <li>4. Shirin Karimi, LCSW, Chief of Social Work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following 15 individuals: AM, CG, CML, DCC, DM, GB, GRJ, KS, LO, LS, MAM, RAG, RG, SM and TM</li> <li>2. MSH Social History Assessments Monitoring Form summary data, August 2010-January 2011</li> <li>3. DMH Integrated Assessments: Social Work Section</li> <li>4. DMH 30-Day Psychosocial Assessments</li> <li>5. MSH's progress report</li> </ol>									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of the Integrated Assessments: Social Work Section due each month during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="991 1268 1890 1416"> <tbody> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate</i></td> <td style="width: 15%;">100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at least the minimum information required in the</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%									
2.	<i>Current, and</i>	100%									
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the</i>	100%									

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		<table border="1" data-bbox="993 190 1892 267"> <tr> <td data-bbox="993 190 1094 267"></td> <td data-bbox="1094 190 1795 267"><i>instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1795 190 1892 267"></td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of 11 individuals to evaluate the Integrated Assessments: Social Work Sections found that 10 assessments were current and comprehensive (AM, CML, DCC, GRJ, KS, LS, MAM, RAG, RG and TM) and one was not current and/or was not comprehensive (DM).</p> <p>A review of the records of 11 individuals to evaluate the 30-Day Psychosocial Assessments found that all 11 assessments were current and comprehensive (AM, CML, DCC, DM, GRJ, KS, LS, MAM, RAG, RG and TM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>instructions as applicable or indicate why the information is not available.</i>	
	<i>instructions as applicable or indicate why the information is not available.</i>				
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of the 30-Day Psychosocial Assessments due each month during the review period (August 2010-January 2011):</p>			

Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1900 345"> <tr> <td data-bbox="993 191 1087 267">4.</td> <td data-bbox="1087 191 1795 267"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1795 191 1900 267">100%</td> </tr> <tr> <td data-bbox="993 267 1087 305">5.</td> <td data-bbox="1087 267 1795 305"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1795 267 1900 305">100%</td> </tr> <tr> <td data-bbox="993 305 1087 345">6.</td> <td data-bbox="1087 305 1795 345"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1795 305 1900 345">100%</td> </tr> </table> <p data-bbox="993 386 1900 456">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 496 1900 678">A review of the records of 15 individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that all 15 assessments identified and resolved factual inconsistencies (AM, CG, CML, DCC, DM, GB, GRJ, KS, LO, LS, MAM, RAG, RG, SM and TM), or stated that there were no inconsistencies.</p> <p data-bbox="993 719 1140 789"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 829 1455 899"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
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5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30 <sup>th</sup> day of an individual's admission; and	<p data-bbox="993 943 1591 976"><b>Current findings on previous recommendations:</b></p> <p data-bbox="993 1016 1455 1086"><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1127 1900 1308"><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of Integrated Assessments: Social Work Section due each month during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="993 1344 1900 1385"> <tr> <td data-bbox="993 1344 1087 1385">7.</td> <td data-bbox="1087 1344 1795 1385"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1795 1344 1900 1385">96%</td> </tr> </table>	7.	<i>Is included in the 7-day integrated assessment</i>	96%						
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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to evaluate timeliness of the Social Work Integrated Assessment found that 14 assessments were timely (AM, CG, CML, DCC, DM, GB, GRJ, KS, LO, LS, RAG, RG, SM and TM) and one was untimely (MAM).</p> <p>Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 634 1892 675"> <tr> <td data-bbox="993 634 1087 675">8.</td> <td data-bbox="1087 634 1793 675"><i>Fully documented by 30<sup>th</sup> day of admission</i></td> <td data-bbox="1793 634 1892 675">92%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that 13 assessments were timely (AM, CG, DCC, DM, GB, GRJ, KS, LO, LS, RAG, RG, SM and TM) and two were untimely (MAM and CLM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>Fully documented by 30<sup>th</sup> day of admission</i>	92%
8.	<i>Fully documented by 30<sup>th</sup> day of admission</i>	92%			
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>			

Section D: Integrated Assessments

		<p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 414 1890 527"> <tr> <td data-bbox="993 414 1087 527">10.</td> <td data-bbox="1087 414 1795 527"><i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i></td> <td data-bbox="1795 414 1890 527">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to evaluate documentation of the individual's social factors and educational status in the Integrated Assessments: Social Work Section found that all 15 assessments included this information (AM, CG, CML, DCC, DM, GB, GRJ, KS, LO, LS, MAM, RAG, RG, SM and TM).</p> <p>Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1047 1890 1161"> <tr> <td data-bbox="993 1047 1087 1161">10.</td> <td data-bbox="1087 1047 1795 1161"><i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i></td> <td data-bbox="1795 1047 1890 1161">100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that all 15 assessments included this</p>	10.	<i>Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or 'Unknown' is checked.</i>	100%	10.	<i>Education describes academic experiences including highest level of education completed, special education needs, if applicable</i>	100%
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		<p>information (AM, CG, CML, DCC, DM, GB, GRJ, KS, LO, LS, MAM, RAG, RG, SM and TM).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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7. Court Assessments		
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	As of the tour conducted in March 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	
D.7.a.vii	previous community releases, if the individual has	

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	had previous CONREP revocations;	
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	

Section D: Integrated Assessments

D.7.c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p><b>Summary of Progress:</b> MSH has continued to maintain substantial compliance with most of the requirements of this section.</p>
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Donnie Yoo, LCSW, Supervising Social Worker</li> <li>2. James Park, LCSW, Supervising Social Worker</li> <li>3. Maribel Forbes, LCSW, Supervising Social Worker</li> <li>4. Shirin Karimi, LCSW, Chief of Social Work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Records of the following 19 individuals: BE, DK, DM, FN, GCB, HD, JH, JMT, JR, JRF, LD, MCM, MH, PB, NAO, SAM, SG, WAS, and ZC</li> <li>2. List of individuals who met discharge criteria but remain hospitalized</li> <li>3. List of individuals assessed to need family therapy</li> <li>4. PSR Mall Hours of Service by Discipline</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program VI, Unit 419) for monthly review of GCB</li> <li>2. WRPC (Program III, Unit 401) for quarterly review of JH</li> <li>3. WRPC (Program III, Unit 409) for annual review of JMT</li> </ol>
E.1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:</p>	<p>Please see sub-cells for compliance findings.</p>

Section E: Discharge Planning and Community Integration

<p>E.1.a</p>	<p>those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 90%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that eight WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (DK, FN, JRF, MCM, PB, SG, WAS and ZC), and one of them did not (MH). The WRPs had opened Focus 11 to address the individual's life goals with appropriate objectives and interventions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>
<p>E.1.b</p>	<p>the individual's level of psychosocial functioning;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing</p>

Section E: Discharge Planning and Community Integration

		<p>Form, MSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 10 individuals found that nine WRPs included a comprehensive review of the individual's psychosocial functioning in the Present Status section (DK, FN, JRF, MCM, MH, PB, SG, WAS and ZC). The individual's psychosocial functioning was not comprehensive in one (BE)</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 96%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that seven WRPs contained documentation that discharge barriers were discussed with the</p>

Section E: Discharge Planning and Community Integration

		<p>individual (DK, JRF, MH, PB, SG, WAS and ZC). The remaining WRP did not (FN). Documentation in SG and MH indicated that the individual did not understand or had difficulty understanding the discharge criteria. In the case of MH, the WRPT referred the individual for a Neuropsychological Assessment. Other WRPTs should follow such documentation to indicate the individual's level of understanding and acceptance of their discharge criteria.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>
E.1.d	<p>the skills and supports necessary to live in the setting in which the individual will be placed.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (DK, FN, JRF, MH, PB, SG, WAS and ZC).</p> <p><b>Compliance:</b></p>

Section E: Discharge Planning and Community Integration

		<p>Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.2	<p>Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 17% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that seven WRPs contained documentation indicating that the individual was an active participant in the discharge process (DK, JRF, MH, PB, SG, WAS and ZC). The remaining one WRP contained no documentation that the individual participated in the discussion (FN).</p> <p>This monitor observed three WRPCs (GCB, JH, and JMT). The WRPTs of these individuals reviewed the individuals' discharge matters with the individuals, engaged the individuals in the discussion, and answered their questions as much as the individuals would participate.</p> <p>A review of the records of eight individuals found that seven WRPs contained measurable objectives and interventions to address the individual's discharge criteria (DK, FN, JRF, PB, SG, WAS and ZC) and one did not (MH).</p>

Section E: Discharge Planning and Community Integration

		<p>A review of the records of eight individuals found that all eight WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (DK, FN, JRF, MH, PB, SG, WAS and ZC).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see subcells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the WRPs of nine individuals found that the objectives and</p>

Section E: Discharge Planning and Community Integration

		<p>discharge criteria were written in behavioral and/or measurable terms in eight WRPs (DK, FN, JRF, PB, SAM, SG, WAS and ZC). The objectives and/or discharge criteria were not written in behavioral and/or measurable terms in the remaining WRP (MH).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.3.b	the staff responsible for implementing the interventions; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs identified the staff member responsible for the interventions (DK, FN, JRF, PB, SAM, SG, WAS and ZC K).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>

Section E: Discharge Planning and Community Integration

E.3.c	The time frames for completion of the interventions.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that six WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (DK, FN, JRF, PB, SG and WAS). The remaining three WRPs did not specify a time frame or the stated time frame was not aligned with the next scheduled WRPC (MH, SAM and ZC). For example, the stated time frame for the next scheduled review for SAM was 1/29/2011, when the quarterly WRPC was on 1/13/2011. Subsequent to the tour, the facility provided an adequate explanation for the varying review time frames.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	<p><b>Compliance:</b> Substantial.</p>

Section E: Discharge Planning and Community Integration

<p>E.4.a</p>	<p>individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Documentation review found 42 names on the list of individuals referred for discharge but still hospitalized. Twenty-five of those on the list were civilly committed and 17 were forensically committed.</p> <p><u>Status of the Civilly Committed:</u> Four of the recent referrals (AS, MS, RS and TC) have yet to be opened and reviewed by Los Angeles County. Seven are waiting for a bed (BW, CR, GG, KB, NM, PC and SS). The status of the remaining 14 is summarized in the table below:</p> <table border="1" data-bbox="991 782 1906 1416"> <thead> <tr> <th data-bbox="991 782 1094 857">ID</th> <th data-bbox="1094 782 1241 857">Referral Date</th> <th data-bbox="1241 782 1906 857">Status as of January 2011</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 857 1094 1045">AD</td> <td data-bbox="1094 857 1241 1045">9/09</td> <td data-bbox="1241 857 1906 1045">Difficulty finding SNF placement due to AD's age. Many consider him too young and suspect he might have the ability to leave the place. Waiting for Los Angeles County SNF for placement (apparently the LAC SNF will have no age limit).</td> </tr> <tr> <td data-bbox="991 1045 1094 1157">DG</td> <td data-bbox="1094 1045 1241 1157">10/09</td> <td data-bbox="1241 1045 1906 1157">The individual regressed medically and has been transferred to SNF unit. The team is awaiting medical clearance before pursuing placement.</td> </tr> <tr> <td data-bbox="991 1157 1094 1232">LO</td> <td data-bbox="1094 1157 1241 1232">2/10</td> <td data-bbox="1241 1157 1906 1232">Alternative level of care suspended until psychiatric and behavioral stability is established.</td> </tr> <tr> <td data-bbox="991 1232 1094 1416">FC</td> <td data-bbox="1094 1232 1241 1416">5/10</td> <td data-bbox="1241 1232 1906 1416">Los Angeles County refused to open case due to uncertainty of the family's capacity to function as conservators. FC has significant medical issues. The County prefers FSP. SW working with family on these issues.</td> </tr> </tbody> </table>	ID	Referral Date	Status as of January 2011	AD	9/09	Difficulty finding SNF placement due to AD's age. Many consider him too young and suspect he might have the ability to leave the place. Waiting for Los Angeles County SNF for placement (apparently the LAC SNF will have no age limit).	DG	10/09	The individual regressed medically and has been transferred to SNF unit. The team is awaiting medical clearance before pursuing placement.	LO	2/10	Alternative level of care suspended until psychiatric and behavioral stability is established.	FC	5/10	Los Angeles County refused to open case due to uncertainty of the family's capacity to function as conservators. FC has significant medical issues. The County prefers FSP. SW working with family on these issues.
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		PD	5/10	Continuing with search for placement. Cedar Street is to review case once MSH sends updated information.
		JC	6/10	Denied by two placement settings (Meadowbrook and Olive Vista). La Paz is considering acceptance but is requesting EKG results to verify JC's health status.
		MO	6/10	Waiting for family to determine conservatorship. MO is making home visits. If family is conservator, MO will be discharged home with FSP services. If not, will wait for opening of the proposed Los Angeles County SNF unit.
		NV	6/10	Los Angeles County has not opened case. Family is increasingly involved in case, and is considering conservatorship.
		HD	8/10	LACC and Private Conservator reviewing placement options (Ane Sippi, Percy Village, and Telecare).
		JF	8/10	Interview with Olive Vista did not go well. JF with a history of living on the street stated he would make a shank for self protection. County is wary of his and others' safety in the community due to this and his history of arson. SW working with JF on his responsibility and role in the community.
		MJ	8/10	Los Angeles County is ready to place MJ at La Casa or similar facility. Court continued to determine Conservatorship status.
		AM	10/10	Los Angeles County will not open case. Individual has late stage Huntington's disease without any psychiatric disorder and therefore does not meet criteria for mental health services. SW working with family to pursue placement at Palmcrest Grand Care Center. AM's half-brother resides in this place.

Section E: Discharge Planning and Community Integration

		SR	11/10	LACC deferred due to recent medication titration. Awaiting medication stability																								
		LM	12/10	LACC requesting updated information from the facility.																								
		<p><u>Status of the Forensically Committed:</u>          Four individuals are waiting for beds (DM, LH, MM and TE) and one has been accepted for placement (ET); CONREP is arranging for the individual's transportation. The status of the remaining 12 individuals is summarized in the table below:</p>																										
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Section E: Discharge Planning and Community Integration

			room, Sylmar needs two females. Thus, Sylmar is working to expedite a female from PSH to share a room with GBM.	
		MO	11/10	MSH is awaiting the resolution on getting MO's fingerprints for green card issuance. MO's family is working with USCIS mobile fingerprint unit to come to MSH to get MO's fingerprints. MSH is also hoping that a court order can be obtained to allow USCIS fingerprint to be accepted by immigration.
		GK	12/10	Court order for placement at Sylmar received (1/3/10) pending next available bed.
		MF	12/10	Interviewed by CONREP, and a representative is to come to MSH to conduct a full evaluation. Meanwhile, CONREP has given a list of five things it expects MF to be working on.
		LD	12/10	Referred to Royale. LD might have to wait a long while to be placed as beds for undocumented clients are limited.
		JK	1/11	Working to get JK into Sylmar.
		<p>As the tables above indicate, the waiting list of those ready to be discharged mostly includes individuals who were referred for discharge during this review period (between August and December 2010). Eight individuals, all of whom were civilly committed, were referred before the review period (AD, DG, FC, JC, LO, MO, NV and PD). The most long-standing referrals are "on hold" due to medical reasons most probably requiring a SNF placement.</p> <p>A review of 33 individuals referred for discharge found that the average stay at MSH (from admission to referral for discharge) was 3.6 years, with a range of three months to 16 years and six months. A review of 15 individuals discharged from MSH during the previous review period found</p>		

Section E: Discharge Planning and Community Integration

		<p>that the time from the date of referral for discharge to actual discharge averaged 19 months, with a range of nine to 32 months).</p> <p>This monitor's discussion with the Chief of Social Work found that MSH continues to deal with external barriers including court reviews, CONREP's changing demands, and most importantly a lack of beds, for example for females at Sylmar, for the medically fragile, and for undocumented individuals.</p> <p>According to the Chief of Social Work, MSH has been working with outside agencies and is seeing improvement in a number of areas, including:</p> <ol style="list-style-type: none"> <li>1. LA County is in the process of opening a locked skilled nursing unit without age limitations. Medical and psychiatric issues will determine placement criteria. The Chief of Social Work feels that this move would increase potential placement for individuals under age 65 with serious health needs.</li> <li>2. MSH has been working with CONREP for consideration of keeping open beds for individuals with a diagnosis of Borderline Personality Disorder.</li> <li>3. MSH's SW staff is willing to mobilize needed resources to accomplish same-day discharges in the interest in not losing opened beds. The Chief of Social Work feels the staff will need at least half a day to make the required arrangements.</li> </ol> <p><b>Current recommendation:</b> Continue current practice.</p>
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (August 2010-January 2011) and reported a mean compliance rate of 97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs contained documentation of the assistance needed by the individual in the new setting (DM, FN, HD, JR, LD, NAO, PB and WAS).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
E.5	For all children and adolescents it serves, each State hospital shall:	<p>The requirements of cell E.5 and sub-cells are not applicable to MSH as it does not serve children and adolescents.</p>
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	<p><b>Summary of Progress on Psychiatric Services:</b></p> <ol style="list-style-type: none"> <li>1. MSH has maintained compliance with most requirements in Section F.1.</li> <li>2. MSH has made further progress in limiting the unjustified use of high-risk medication (benzodiazepines, anticholinergics and polypharmacy) and improved its practice in the use of emergency medications (PRN/Stat).</li> <li>3. MSH has maintained progress in the laboratory monitoring of the risks of new generation antipsychotic medications and strengthened progress in the monitoring of individuals suffering from tardive dyskinesia, including the provision of neurological consultations for all individuals with abnormal AIMS score to clarify the diagnosis in questionable cases.</li> <li>4. Although the number of ADRs reported has declined, MSH has conducted adequate analysis of ADRs that reached severity thresholds requiring this analysis.</li> <li>5. MSH has conducted adequate DUEs and strengthened medication variance reporting, data presentation, assessment of trends and patterns, and development and implementation of corrective action.</li> </ol> <p>In order to maintain the current level of compliance and achieve compliance with all requirements in this section, the facility needs to:</p> <ol style="list-style-type: none"> <li>1. Increase reporting of ADRs and ensure that the occurrence of metabolic disorders secondary to treatment with new generation antipsychotic medications is reported as ADR.</li> <li>2. Provide complete data set regarding outcomes of mental health service and provide an explanation for missing data.</li> <li>3. Ensure proper formulation of the risk/benefit analysis regarding the use of new generation antipsychotic medications for individuals suffering from metabolic disorders.</li> </ol>

	<p><b>Summary of Progress on Psychological Services:</b></p> <ol style="list-style-type: none"><li>1. MSH has significantly increased the number of behavioral intervention plans to address the needs of the individuals with poor social skills, coping skills, and emotional regulation; and those needing support while they work through their mental illness.</li><li>2. MSH's Psychological Specialty Services Committee has improved its process of reviewing and determining the service needs of individuals reviewed at the ETRC/PSSC meeting.</li><li>3. MSH now has put in motion proactive assessment and milieu interventions for individuals admitted with a history of challenging behaviors. This process needs refinement.</li><li>4. MSH's interdisciplinary practice now is more visible, especially between Psychiatry and Psychology.</li></ol> <p><i>Areas of need include:</i></p> <ol style="list-style-type: none"><li>1. <i>Ensure that there is sufficient number of DCAT/PBS teams to provide the necessary services to the individuals and to support the unit staff.</i></li><li>2. <i>Integrate medical/psychiatry variables into the Structural/Functional assessment and Functional Analysis.</i></li><li>3. <i>Increase the number of Cognitive Remediation groups.</i></li><li>4. <i>Train WRPTs to provide more input with individuals to make By Choice point allocations to impact their participation in PSR services and individual therapies and activities.</i></li><li>5. <i>Train WRPTs to allocate the 50% of the points under their control to help the individual improve participation in activities and therapies.</i></li></ol> <p><b>Summary of Progress on Nursing Services:</b> MSH has maintained substantial compliance with requirements pertaining to documentation regarding PRN and Stat medications.</p>
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	<p><b>Areas of need include:</b></p> <ol style="list-style-type: none"><li>1. <i>MSH needs to focus its efforts on implementing effective strategies to address the problematic nursing issues regarding changes in status to ensure that the nursing assessments and nursing documentation are clinically adequate and appropriate.</i></li><li>2. <i>The facility also needs to ensure that there is a system of review for individuals who are bed-bound to ensure that individuals are not rendered bed-bound due to a lack of adaptive equipment.</i></li></ol> <p><b>Summary of Progress on Rehabilitation Therapy Services:</b></p> <ol style="list-style-type: none"><li>5. MSH attained substantial compliance with the requirements of F.4.a.i and maintained substantial compliance with the requirements of F.4.a.ii, F.4.b., and F.4.d.</li><li>6. MSH has made some improvements but has not yet attained substantial compliance with the requirements of F.4.c.</li></ol> <p><b>Summary of Progress on Nutrition Services:</b></p> <p>MSH has maintained substantial compliance with the requirements of F.5.b and F.5.d, but compliance with the requirements of F.5.a, F.5.c., and F.5.e has declined.</p> <p><b>Summary of Progress on Pharmacy Services:</b></p> <p>As of the tour conducted in September 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p> <p><b>Summary of Progress on General Medical Services:</b></p> <ol style="list-style-type: none"><li>1. MSH has re-attained substantial compliance with all of the requirements in this section.</li></ol>
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	<p>2. The neurological assessments of individuals with seizure disorders have improved significantly due to the contributions of the new behaviorally trained neurologist.</p> <p>3. The quality of medical assessment upon return transfer from general hospitals has improved significantly.</p> <p><b>Areas of need include:</b> <i>In order to maintain substantial compliance, the facility needs to ensure that the assessment of individuals upon return from outside hospitalization includes a review of the factors contributing to the diagnoses that were established during outside hospitalization (particularly when these conditions were not predictable based on the individual's course at MSH).</i></p> <p><b>Summary of Progress on Infection Control:</b> MSH has maintained substantial compliance with most of the requirements of this section.</p> <p><b>Areas of need include:</b> <i>MSH needs to implement a system addressing and tracking refusals for immunizations and strategies to increase compliance rates in the areas in which they have decreased since the last review in order to achieve overall substantial compliance in Section F.8.</i></p> <p><b>Summary of Progress on Dental Services</b> MSH's Dental Department has continued to maintain substantial compliance in all but one area of the Enhancement Plan; refusals. The documentation of refusals from the Dental Department is consistently clear.</p> <p><b>Areas of need include:</b> <i>Concentrated efforts are needed to implement a consistent system addressing dental refusals at the level of the WRPTs.</i></p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Julie Duane, Nurse Practitioner, Central Nursing Services</li> <li>2. Michael Barsom, MD, Medical Director</li> <li>3. Nady Hanna, MD, Assistant Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 36 individuals: AB-1, AB-2, AF, BE, BJ, DPP, EEA, FDA, FJA, GAB, GWA, JC, JH, JM, JNN, KLK, LDH, LMN, LO, MG, MKD, MLC, MLM, MN, MR, NK, PC, RC, RG, SMA, SR, TAE, TLH, VA, WHB and YK</li> <li>2. DMH Admission Psychiatric Assessment Audit summary data (August - January 2010/2011)</li> <li>3. DMH Integrated Psychiatry Assessment Audit summary data (August - January 2010/2011)</li> <li>4. DMH Monthly PPN Audit summary data (August - January 2010/2011)</li> <li>5. DMH PRN and Stat monitoring summary data (August - January 2010/2011)</li> <li>6. DMH Movement Disorder Monitoring summary data (August - January 2010/2011)</li> <li>7. ADR Tracking Log for the review period</li> <li>8. MSH aggregated data regarding ADRs (August - January 2010/2011)</li> <li>9. Last ten ADRs for this reporting period</li> <li>10. Intensive Case Analyses (ICAs) completed during this review period for the following four individuals: BA, BG, CW, and MS</li> <li>11. Drug Utilization Evaluations (DUEs) completed during this review period: <ul style="list-style-type: none"> <li>• New Diagnosis of Diabetes Mellitus and Second Generation Antipsychotics</li> <li>• Divalproex Sprinkles</li> <li>• Azithromycin</li> </ul> </li> </ol>

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		<ul style="list-style-type: none"> <li>• Benzodiazepine - Substance Abuse Part I</li> <li>• Benzodiazepine - Substance Abuse Part II</li> </ul> <ol style="list-style-type: none"> <li>12. Last ten MVRs for this reporting period</li> <li>13. MSH aggregated data regarding medication variances (August - January 2010/2011)</li> <li>14. Pharmacy and Therapeutics Committee Minutes during the review period</li> <li>15. Report from Tardive Dyskinesia database: Schedule of Neurology Clinic visits for AIMS-positive individuals</li> <li>16. MSH document regarding continuing medical education provided to psychiatrists</li> </ol>
F.1.a	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Continue to provide updates to medication guidelines and status of implementation at the facility.</p> <p><b>Findings:</b> The following outlines the significant changes to the guidelines during this review period. These changes were approved at the January 14, 2011 meeting of the Psychopharmacology Advisory Committee and are to be incorporated into the 2012 iteration of the DMH Psychotropic Medication Policy:</p> <ol style="list-style-type: none"> <li>1. The dosing strategy for decanoate loading was changed from "300 mg IM every two weeks" to "300 mg IM every one to two weeks." This change is informational and does not obligate any prescriber to follow the loading strategy.</li> <li>2. A section was added regarding the use of depot olanzapine (Zyprexa Relprevv) but this medication is not available in DMH facilities.</li> <li>3. The section pertaining to Drug Usage Evaluations (DUEs) will be amended to reflect that DUEs targeting medications taken by fewer</li> </ol>

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		<p>than 20 individuals will have all those individuals included in the DUE.</p> <p>4. Lamotrigine protocol was revised to include "headaches including due to aseptic meningitis" as one of the possible side effects.</p> <p>MSH follows the DMH Psychotropic Medication Guidelines and updates are added periodically or as received from the PAC</p> <p><b>Recommendation 2, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess compliance, based on average samples of 83%, 65% and 23%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to provide updates to medication guidelines and status of implementation at the facility.</li> <li>2. Continue to monitor this requirement.</li> </ol>						
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="989 1149 1892 1227"> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> <tr> <td>8.</td> <td>Plan of care</td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Admission Psychiatric Assessment			8.	Plan of care	100%
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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	100%									
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F.1.a.iii	tailored to each individual's symptoms;	Same as in F.1.a.ii.															
F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	Same as in F.1.a.ii.															

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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 228 1887 565"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 269 1087 337">2.</td> <td data-bbox="1087 269 1793 337"><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i></td> <td data-bbox="1793 269 1887 337">99%</td> </tr> <tr> <td data-bbox="991 337 1087 565">5.</td> <td data-bbox="1087 337 1793 565"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td data-bbox="1793 337 1887 565">100%</td> </tr> </tbody> </table> <p data-bbox="991 607 1877 675">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>	Monthly PPN			2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	99%	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	100%
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F.1.a.vi	modified based on clinical rationales;	Same as in F.1.a.ii.									
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.a.ii.									
F.1.a.viii	Properly documented.	<table border="1" data-bbox="991 938 1892 1089"> <tbody> <tr> <td data-bbox="991 938 1451 976">Admission Psychiatric Assessment</td> <td data-bbox="1451 938 1793 976">8.a, 8.b and 8.c</td> <td data-bbox="1793 938 1892 976">100%</td> </tr> <tr> <td data-bbox="991 976 1451 1052">Integrated Assessment (Psychiatry)</td> <td data-bbox="1451 976 1793 1052">7 and 10</td> <td data-bbox="1793 976 1892 1052">100%</td> </tr> <tr> <td data-bbox="991 1052 1451 1089">Monthly PPN</td> <td data-bbox="1451 1052 1793 1089">2, 3 and 5</td> <td data-bbox="1793 1052 1892 1089">100%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2, 3 and 5	100%
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p data-bbox="991 1138 1591 1166"><b>Current findings on previous recommendations:</b></p> <p data-bbox="991 1211 1570 1239"><b>Recommendations 1 and 2, September 2010:</b></p> <ul data-bbox="991 1247 1503 1312" style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Same as in D.1.f.</li> </ul> <p data-bbox="991 1357 1104 1385"><b>Findings:</b></p> <p data-bbox="991 1393 1898 1421">MSH used the standardized DMH Monthly PPN tool to assess compliance,</p>									

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based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (August 2010 - January 2011). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 24% and 27% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

<b>Monthly PPN</b>		
6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	100%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

<b>Nursing Services PRN</b>		
1.	<i>Safe administration of PRN medication.</i>	99%
2.	<i>Documentation of the circumstances requiring PRN medication.</i>	99%
3.	<i>Documentation of the individual's response to PRN medication.</i>	99%

Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.

<b>Nursing Services Stat</b>		
1.	<i>Safe administration of Stat medication.</i>	99%
2.	<i>Documentation of the circumstances requiring Stat medication.</i>	98%
3.	<i>Documentation of the individual's response to Stat medication.</i>	98%

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Same as in D.1.f.</li> </ol>
F.1.c	<p>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, September 2010:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:             <ol style="list-style-type: none"> <li>a. Benzodiazepines for 60 days or more;</li> <li>b. Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>c. Benzodiazepines and have any diagnosis of cognitive impairment;</li> <li>d. Anticholinergics for 60 days or more days;</li> <li>e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>f. Intra-class polypharmacy; and</li> <li>g. Inter-class polypharmacy.</li> </ol> </li> <li>3. Ensure that the response to Recommendation 2, sub-items a and d, addresses use for 60 or more days only.</li> </ol> <p><b>Findings:</b> MSH used the standardized DMH Monthly PPN Audit Form to assess compliance based on an average sample of 23% of individuals who have been hospitalized for 90 or more days during the review period (August</p>

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		<p>2010 - January 2011):</p> <table border="1" data-bbox="991 264 1892 527"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1094 527">5.</td> <td data-bbox="1094 305 1793 527"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td data-bbox="1793 305 1892 527">100%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Additionally, MSH reported the following comparative data:</p> <table border="1" data-bbox="991 748 1892 1421"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 829 1045 971">1.</td> <td data-bbox="1045 829 1610 971"><i>Total number of individuals receiving benzodiazepines for 60 days or more [progress report did not make reference to 60+ days]</i></td> <td data-bbox="1610 829 1751 971">35</td> <td data-bbox="1751 829 1892 971">20</td> </tr> <tr> <td data-bbox="991 976 1045 1159">2.</td> <td data-bbox="1045 976 1610 1159"><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more same as above, no ref to 60 days</i></td> <td data-bbox="1610 976 1751 1159">25</td> <td data-bbox="1751 976 1892 1159">18</td> </tr> <tr> <td data-bbox="991 1164 1045 1344">3.</td> <td data-bbox="1045 1164 1610 1344"><i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td data-bbox="1610 1164 1751 1344">7</td> <td data-bbox="1751 1164 1892 1344">5</td> </tr> <tr> <td data-bbox="991 1349 1045 1421">4.</td> <td data-bbox="1045 1349 1610 1421"><i>Total number receiving anticholinergics for 60 days or more same as above, no ref</i></td> <td data-bbox="1610 1349 1751 1421">64</td> <td data-bbox="1751 1349 1892 1421">24</td> </tr> </tbody> </table>	Monthly PPN			5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	100%		Indicators	Previous period	Current period	1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more [progress report did not make reference to 60+ days]</i>	35	20	2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more same as above, no ref to 60 days</i>	25	18	3.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	7	5	4.	<i>Total number receiving anticholinergics for 60 days or more same as above, no ref</i>	64	24
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			<i>to 60 days</i>		
		5.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	7	3*
		6.	<i>Total number with intra-class polypharmacy</i>	242	240
		7.	<i>Total number with inter-class polypharmacy</i>	91	89
<p>*None of these individuals who received anticholinergic medications had a diagnosis of tardive dyskinesia.</p> <p>The facility's data showed the following positive trends since the ;last review:</p> <ol style="list-style-type: none"> <li>1. The use of benzodiazepines has decreased by 43%.</li> <li>2. The use of benzodiazepines in individuals with diagnosis of substance abuse has decreased by 28%.</li> <li>3. The use of benzodiazepines in individuals who have diagnosis of cognitive impairment has decreased by 29% from an already very low base.</li> <li>4. The use of anticholinergics has decreased by 64%.</li> <li>5. The use of anticholinergics in individuals who have diagnosis of cognitive impairment has decreased by 57% from an already very low base.</li> </ol> <p>There was no significant change in the use of intra-class and inter-class polypharmacy.</p> <p><b>Other findings:</b> This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p>					

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		<ol style="list-style-type: none"> <li>1. Benzodiazepines in the presence of diagnoses of substance use disorders and/or cognitive disorders;</li> <li>2. Anticholinergic medications for individuals diagnosed with cognitive disorders;</li> <li>3. Anticholinergic medications for elderly individuals; and</li> <li>4. Various forms of polypharmacy.</li> </ol> <p>This monitor also reviewed the charts of a number of individuals receiving the above types of medication regimens. The following outlines the findings from these reviews (the diagnosis is listed only if it signifies a high-risk condition):</p> <p><b><u>Benzodiazepine use</u></b></p> <table border="1" data-bbox="991 711 1885 1133"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>EEA</td> <td>Clonazepam</td> <td>Vascular Dementia With Behavioral Disturbance</td> </tr> <tr> <td>JM</td> <td>Clonazepam</td> <td>Polysubstance Dependence and Mild Mental Retardation</td> </tr> <tr> <td>JNN</td> <td>Clonazepam</td> <td>Cannabis Abuse</td> </tr> <tr> <td>KLK</td> <td>Lorazepam</td> <td></td> </tr> <tr> <td>LDH</td> <td>Lorazepam</td> <td></td> </tr> <tr> <td>LO</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>MLM</td> <td>Lorazepam</td> <td></td> </tr> <tr> <td>VA</td> <td>Clonazepam</td> <td>Alcohol Abuse</td> </tr> </tbody> </table> <p>The review found substantial compliance in the charts of EEA, JM, JNN, LDH, LO, MLM and VA and partial compliance in the chart of KLK. The facility's databases showed that no individual who was diagnosed with substance use and/or cognitive impairment received current treatment with lorazepam for 60 or more days. This represented significant further progress since the last review.</p>	Individual	Medication(s)	Diagnosis	EEA	Clonazepam	Vascular Dementia With Behavioral Disturbance	JM	Clonazepam	Polysubstance Dependence and Mild Mental Retardation	JNN	Clonazepam	Cannabis Abuse	KLK	Lorazepam		LDH	Lorazepam		LO	Clonazepam	Polysubstance Dependence	MLM	Lorazepam		VA	Clonazepam	Alcohol Abuse
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		<p><b><u>Anticholinergic use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AMR</td> <td>Benztropine</td> <td>None</td> </tr> <tr> <td>FJA</td> <td>Hydroxyzine</td> <td>None</td> </tr> <tr> <td>PC</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning partial blurred vision as a target sx</td> </tr> <tr> <td>SMA</td> <td>Benztropine</td> <td>None</td> </tr> <tr> <td>TAE</td> <td>Benztropine</td> <td>None</td> </tr> </tbody> </table> <p>The review found substantial compliance in the charts of AMR, FJA, SMA and TAE. The facility's databases showed that no individual with a diagnosis of tardive dyskinesia and only one individual (PC) with a diagnosis of cognitive disorder received current treatment with an anticholinergic agent for 60 or more days.</p> <p><b><u>Anticholinergic use for elderly individuals</u></b></p> <p>The facility's databases showed that no individual age 65 years or older received anticholinergic treatment for 60 or more days.</p> <p><b><u>Polypharmacy use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AB</td> <td>Bupropion, chlorpromazine, divalproex, lorazepam and diphenhydramine</td> <td></td> </tr> <tr> <td>AF</td> <td>Fluphenazine, clozapine, benztropine, citalopram, divalproex and clonazepam partial?</td> <td></td> </tr> <tr> <td>FDA</td> <td>Clozapine, haloperidol, paroxetine and clonazepam,</td> <td></td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	AMR	Benztropine	None	FJA	Hydroxyzine	None	PC	Benztropine	Borderline Intellectual Functioning partial blurred vision as a target sx	SMA	Benztropine	None	TAE	Benztropine	None	Individual	Medication(s)	Diagnosis	AB	Bupropion, chlorpromazine, divalproex, lorazepam and diphenhydramine		AF	Fluphenazine, clozapine, benztropine, citalopram, divalproex and clonazepam partial?		FDA	Clozapine, haloperidol, paroxetine and clonazepam,	
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		JC	Lithium, haloperidol, sertraline, olanzapine and topiramate	
		MKD	Haloperidol, ziprasidone, lamotrigine and diphenhydramine	
		MR	Olanzapine, ziprasidone, aripiprazole, bupropion, topiramate and benztropine	
		NK	Haloperidol, quetiapine, topiramate, duloxetine and diphenhydramine	
		RG	Risperidone, divalproex, trazodone and benztropine	
		<p>This review found substantial compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:             <ol style="list-style-type: none"> <li>a. Benzodiazepines for 60 days or more;</li> <li>b. Benzodiazepines and have any diagnosis of substance use disorder;</li> <li>c. Benzodiazepines and have any diagnosis of cognitive impairment;</li> <li>d. Anticholinergics for 60 days or more days;</li> <li>e. Anticholinergics and have any diagnosis of cognitive impairments and/or tardive dyskinesia and/or are age 65 or above;</li> <li>f. Intra-class polypharmacy; and</li> <li>g. Inter-class polypharmacy.</li> </ol> </li> </ol>		

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<p>F.1.d</p>	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Monthly PPN Auditing Form, MSH assessed its compliance based on an average sample of 23% of individuals receiving these medications during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 565 1890 824"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">5</td> <td><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i></td> <td style="text-align: center;">100%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor reviewed the charts of ten individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 1193 1873 1416"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>AB</td> <td>Clozapine</td> <td>Diabetes Mellitus and Hypertriglyceridemia</td> </tr> <tr> <td>BJ</td> <td>Quetiapine</td> <td>Hyperlipidemia and Hypertension</td> </tr> <tr> <td>DPP</td> <td>Risperidone</td> <td>Diabetes Mellitus, Obesity, Dyslipidemia and Hypertension</td> </tr> </tbody> </table>	Monthly PPN			5	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications</i>	100%	Individual	Medication(s)	Diagnosis	AB	Clozapine	Diabetes Mellitus and Hypertriglyceridemia	BJ	Quetiapine	Hyperlipidemia and Hypertension	DPP	Risperidone	Diabetes Mellitus, Obesity, Dyslipidemia and Hypertension
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		<i>GAB</i>	Clozapine and thiothixene	Diabetes Mellitus, Obesity, Hyperlipidemia, Hyperprolactinemia and Hypertension
		<i>GWA</i>	Olanzapine	Diabetes Mellitus
		<i>LMN</i>	Quetiapine and paliperidone	Diabetes Mellitus and Hyperlipidemia
		<i>MG</i>	Risperidone	Diabetes Mellitus, Obesity and Dyslipidemia
		<i>MLC</i>	Quetiapine	Diabetes Mellitus, Obesity and Hypertension
		<i>RC</i>	Olanzapine	Diabetes Mellitus and Hyperlipidemia
		<i>TLH</i>	Olanzapine	Diabetes Mellitus, Obesity, Hyperlipidemia, Hyperprolactinemia and Hypertension
		<p>In general, the review found evidence of adequate laboratory and clinical monitoring of these individuals. However, the following process deficiencies were identified:</p> <ol style="list-style-type: none"> <li>1. The psychiatric progress notes did not address the specific metabolic status of an individual who experienced serious elevation of serum lipase during the interval (<i>RC</i>). However, the individual's status improved at a later date.</li> <li>2. The psychiatric progress notes did not address significant elevation of serum triglycerides in an individual who was diagnosed with hyperlipidemia and received high-risk treatment with olanzapine (<i>MG</i>).</li> <li>3. There was no monthly psychiatric documentation of the significance (and status of) fluctuating serum lipase levels within a very high range in an individual who suffered from multiple metabolic disorders (<i>GAB</i>). However, the Physician and Surgeon initiated a work-up to assess the risk of pancreatitis.</li> <li>4. In general, the psychiatric progress notes did not address the changes in the metabolic status of individuals suffering from a</li> </ol>		

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		<p>variety of metabolic disorders in specific terms. Instead, most of the notes included generic statements that the medications may be contributing to these disorders</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure correction of the above-mentioned deficiencies.</li> </ol>															
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Movement Disorders Auditing Form, MSH assessed its compliance based on average samples ranging from 83% to 100% of individuals relevant to each indicator during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1008 1894 1421"> <tr> <td data-bbox="991 1008 1087 1084">1.</td> <td data-bbox="1087 1008 1793 1084"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 1008 1894 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1087 1195">2.</td> <td data-bbox="1087 1084 1793 1195"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1084 1894 1195">100%</td> </tr> <tr> <td data-bbox="991 1195 1087 1305">3.</td> <td data-bbox="1087 1195 1793 1305"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 1195 1894 1305">100%</td> </tr> <tr> <td data-bbox="991 1305 1087 1382">4.</td> <td data-bbox="1087 1305 1793 1382"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 1305 1894 1382">100%</td> </tr> <tr> <td data-bbox="991 1382 1087 1421">5.</td> <td data-bbox="1087 1382 1793 1421"><i>A neurology consultation/Movement Disorders Clinic</i></td> <td data-bbox="1793 1382 1894 1421">100%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	100%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	100%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	100%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic</i>	100%
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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b>            During this review period, MSH implemented corrective actions to improve the accuracy of the facility's database and tracking and reporting of TD by practitioners. In this regard, all individuals with a positive AIMS test were evaluated for TD by the facility's neurologist and the senior psychiatrists continued to provide consultations for all individuals with positive AIMS regardless of the score. The electronic version of AIMS was still in development.</p> <p>The facility's database regarding TD showed the following:</p> <ol style="list-style-type: none"> <li>1. The average number of individuals with TD diagnosis was 10 compared to nine during the previous period.</li> <li>2. The total number of individuals with history of TD diagnosis has remained the same at five.</li> <li>3. The total number of individuals with positive AIMS test that did not reach the diagnostic threshold of TD has decreased from 41 during the previous review period to 28 during this review period.</li> </ol> <p><b>Other findings:</b>            This monitor reviewed the charts of six individuals (BE, JH, MN, SR,</p>													

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		<p>WHB and YK) who were diagnosed with tardive dyskinesia as per the facility's database. This review found that MSH has made further progress in the following areas:</p> <ol style="list-style-type: none"> <li>1. Completion of AIMS tests upon admission of all individuals to the facility;</li> <li>2. Completion of quarterly AIMS testing for individuals with TD diagnosis;</li> <li>3. Inclusion of TD diagnosis, focus and corresponding objectives and interventions related to TD;</li> <li>4. Tracking of AIMS scores as documented in the psychiatric progress notes;</li> <li>5. Use of learning-based objectives focused on understanding, tracking and reporting of the movement disorders and participation in testing by the individuals (BE);</li> <li>6. Use (or consideration) of safer antipsychotic medication regimens (in general);</li> <li>7. Avoidance of high-risk treatment of anticholinergic medications; and</li> <li>8. Neurological consultation for all individuals with positive AIMS score.</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1,2,3 and 4, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Increase reporting of ADRs.</li> <li>• Ensure accuracy of data regarding the probability and severity scales.</li> <li>• Continue review and analysis of ADRs and present summary of aggregated data to address the following:</li> </ul>

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		<p>a. The number of ADRs reported each month during the review period compared with number reported during the previous period;</p> <p>b. Classification of probability and severity of ADRs;</p> <p>c. Any negative outcomes for individuals who were involved in serious reactions; and</p> <p>d. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</p> <ul style="list-style-type: none"> <li>• Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</li> </ul> <p><b>Findings:</b> The following summarizes the facility's data:</p> <table border="1" data-bbox="991 782 1864 1242"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>101</td> <td>61</td> </tr> <tr> <td colspan="3"><b>Classification of Probability of ADRs</b></td> </tr> <tr> <td>Doubtful</td> <td>3</td> <td>4</td> </tr> <tr> <td>Possible</td> <td>64</td> <td>32</td> </tr> <tr> <td>Probable</td> <td>29</td> <td>24</td> </tr> <tr> <td>Definite</td> <td>5</td> <td>1</td> </tr> <tr> <td colspan="3"><b>Classification of Severity of ADRS</b></td> </tr> <tr> <td>Mild</td> <td>34</td> <td>21</td> </tr> <tr> <td>Moderate</td> <td>65</td> <td>36</td> </tr> <tr> <td>Severe</td> <td>2</td> <td>4</td> </tr> </tbody> </table> <p>The facility's data showed adequate classification by probability and severity of ADRs.</p> <p>MSH conducted intensive case analyses (ICAs) on all four severe ADRs.</p>		Previous period	Current period	Total ADRs	101	61	<b>Classification of Probability of ADRs</b>			Doubtful	3	4	Possible	64	32	Probable	29	24	Definite	5	1	<b>Classification of Severity of ADRS</b>			Mild	34	21	Moderate	65	36	Severe	2	4
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		<p>These reactions involved the following:</p> <ol style="list-style-type: none"><li>1. Clozapine-induced ileus;</li><li>2. Divalproex-induced pancreatitis;</li><li>3. Elevated lipase accompanied by symptoms suggestive of acute pancreatitis (quetiapine and clonazepam); and</li><li>4. Abdominal pain due to acute pancreatitis (acetaminophen and simvastatin).</li></ol> <p>The ICAs used appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. Based on the facility's report, none of the ADRs resulted in permanent harm to any individual.</p> <p>The facility's data indicated a decrease in the number of reported ADRS compared to the last review period. The most common type of adverse drug reactions was extrapyramidal side effects (#9) followed by elevated amylase/lipase (#8) and prolactin elevation (#7). The facility reported that the decrease in the total number of ADRs was not expected and not attributable to any change in methodology. The facility identified the 10% decrease in the average daily census as a contributing factor. Additionally, based on the facility's report, there appeared to be reluctance on the part of medical and nursing staff to report ADRs. This was assessed to be caused by misperception about the punitive nature of reporting ADRs and lack of motivation and understanding of the importance of reporting all ADRs.</p> <p>To address the decrease in reporting, the Chair of the P&amp;T Committee discussed the issue with the medical staff during the Department meeting in October 2010 and an increase was observed in the number of ADRs reported subsequent to this meeting. This issue was also brought to the Quality Council and discussed with nursing administration to increase awareness about reporting ADRs by nursing. All staff were</p>
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		<p>informed that the ADR process is non-punitive and were encouraged to report any suspected adverse reaction.</p> <p><b>Compliance:</b> Partial relative to the requirement to identify adverse drug reactions.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Increase reporting of ADRs and ensure that ADRs also include metabolic disorders secondary to the use of new generation antipsychotic medications.</li> <li>2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:             <ol style="list-style-type: none"> <li>a. The number of ADRs reported each month during the review period compared with number reported during the previous period;</li> <li>b. Classification of probability and severity of ADRs;</li> <li>c. Any negative outcomes for individuals who were involved in serious reactions; and</li> <li>d. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).</li> </ol> </li> <li>3. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</li> </ol>
F.1.g	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions.</p> <p><b>Findings:</b> During this review period, MSH conducted the following DUEs:</p>

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	<p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<ol style="list-style-type: none"> <li>1. Patterns of use of benzodiazepines (Parts I and II);</li> <li>2. Adherence to azithromycin dosing and indications;</li> <li>3. Adherence to the recommendations of the P&amp;T Committee regarding use of liquid valproic acid instead of divalproex sprinkles; and</li> <li>4. Incidence of new onset diabetes mellitus with the use of second generation antipsychotic agents.</li> </ol> <p>The DUEs utilized appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions.</p>
<p>F.1.h</p>	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Present data to address the following:</p> <ol style="list-style-type: none"> <li>a) Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;</li> <li>b) Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>c) Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);</li> <li>d) Number of critical breakdown points by outcome;</li> <li>e) Clinical information regarding each variance (category E or above) and the outcome to the individual involved;</li> <li>f) Information regarding any intensive case analysis done for each</li> </ol>

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reaction that was classified as category E or above; and  
 g) Outline of ICAs, including description of variance, recommendations and actions taken.

**Findings:**

MSH reported the following data regarding MVRs:

Number of Medication Variances	Previous Period	Current Period
Prescribing	28	40
Transcribing	221	229
Ordering/Procurement	155	125
Dispensing	184	165
Administration	758	489
Drug Security	139	77
Documentation	431	720
<b>Total variances</b>	<b>1916</b>	<b>1845</b>

The numbers of MVRs reported in this section were consistent with the numbers reported in the Key Indicators for the current review period.

Total Critical Breakdown Points	Previous Period	Current Period
Total Critical Breakdown Points	612	449
Potential MVRs	389	240
Actual MVRs	223	209
# Prescribing	25	25
# Transcribing	82	67
# Order/Procure	16	17
# Dispensing	28	29
# Administration	142	137

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		# Drug Security	18	14		
		# Document	301	160		
		Outcome A	1	0		
		Outcome B	388	240		
		Outcome C	218	206		
		Outcome D	5	2		
		Outcome E	0	1		
		Outcome F	0	0		
		Outcome G	0	0		
		Outcome H	0	0		
		Outcome I	0	0		
		<p><b>Recommendation 2, March 2010:</b> Provide summary of analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p><b>Findings:</b> The facility conducted adequate review and analysis of its variance data during this review period. The total number of medication variances by dose (1845) showed a small decrease (3.7%) compared to the previous review period (1916). The total numbers by dose of drug security, administration, ordering/ procurement and dispensing variances fell from the previous review period, while prescribing and documentation errors increased. The number of transcribing errors was little changed.</p> <p>The trend of elevated Transcribing, Administration, and Documentation variances has persisted through this review period, though as aforementioned, a decline in Administration variances over the last review period was observed. The facility reported adequate corrective actions to address the patterns/trends of variances in transcribing, administration and documentation variances.</p>				

		<p><b>Recommendation 3, September 2010:</b>          Improve documentation of all ICAs of variances.</p> <p><b>Findings:</b>          None of the variances reached severity threshold for an ICA (category E or higher). However, the facility conducted adequate analysis of three variances that were classified as category D. These variances involved the following:</p> <ol style="list-style-type: none"> <li>1. Administration of haloperidol decanoate instead on fluphenazine decanoate;</li> <li>2. Administration of insulin instead of Humalog due to the use of medication treatment record of another individual; and</li> <li>3. Missing three doses of sertraline and bupropion due to a transcription error.</li> </ol> <p><b>Compliance:</b>          Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Present data regarding the following:             <ol style="list-style-type: none"> <li>a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period;</li> <li>b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period;</li> <li>c. Number of variances by category (e.g. prescription, administration, documentation, etc.);</li> <li>d. Number of variances by outcome;</li> <li>e. Clinical information regarding each variance (Category E or above) and the outcome to the individual involved;</li> <li>f. Information regarding any intensive case analysis done for each</li> </ol> </li> </ol>
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		<p>reaction that was classified as Category E or above; and</p> <p>g. Outline of ICAs, including description of variance, recommendations and actions taken.</p> <p>2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Same as in F.1.a through F.1.h.</li> <li>• Provide outcome data as requested by this monitor and ensure consistency of data with similar data presented in other sections.</li> </ul> <p><b>Findings:</b></p> <p>During this review period, the facility gathered and presented outcome data that addressed the rate per 1000 days of the following indicators:</p> <ol style="list-style-type: none"> <li>1. Any aggression to self resulting in major injury;</li> <li>2. Any peer-to-peer aggression resulting in major injury;</li> <li>3. Any aggression to staff resulting in major injury;</li> <li>4. Individuals having alleged abuse/neglect/exploitation;</li> <li>5. Individuals having confirmed abuse /neglect exploitation;</li> <li>6. Individuals with two or more intra-class psychotropic medications for psychiatric reasons;</li> <li>7. Individuals with four or more inter-class psychotropic medications for psychiatric reasons;</li> <li>8. Any event involving a medication error which results in a major injury or exacerbation of a disease or disorder;</li> <li>9. Unique count of individuals in restraint;</li> <li>10. Unique count of restraint events;</li> <li>11. Unique count of individuals in seclusion;</li> <li>12. Unique count of seclusion events;</li> <li>13. Individuals on benzodiazepines who are diagnosed with substance use;</li> </ol>

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		<p>14. Individuals on benzodiazepine diagnosed with cognitive disorder;  15. Elderly on anticholinergic medications (age &gt;65);  16. Individuals diagnosed with cognitive disorder on anticholinergics;  17. Individuals diagnosed with TD prescribed anticholinergics; and  18. Count of severe ADRs.</p> <p>In addition, the facility presented data regarding the outcomes of substance use services but inconsistencies were noted (see C.2.o).</p> <p>The facility did not provide data regarding the confirmation of abuse/neglect allegations for the months of November 2010 to January 2011 and no explanation was provided regarding the lack of data. In addition, no data were provided for the month of January for most indicators without an explanation. However, the data that were provided in this section were consistent with similar data presented in other relevant sections of the report.</p> <p>The compilation of the measures in this cell may be of benefit to the facilities and others as another tool in reviewing overall performance in those sections of the EP that can yield meaningful numerical outcomes. These data should also serve as an additional tool in guiding performance improvement efforts and the oversight function of the facility's Quality Council (see section I.2).</p> <p><b>Compliance:</b>  Partial due to incomplete data and inconsistencies within data regarding outcomes of substance use services. This rating addresses tracking of trends as required in this cell. However, tracking is only one aspect of quality management/performance as required in Section I of the EP (please refer to this section for overall assessment of quality management/performance improvement).</p>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Same as in F.1.a through F.1.h.</li> <li>2. Continue to provide above outcome data for the review period.</li> <li>3. Ensure completeness of data and provide and explanation for incomplete data.</li> </ol>
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in F.1.a through F.1.h.</p> <p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in F.1.a through F.1.h.</p>

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F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Findings:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Compliance:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p> <p><b>Current recommendations:</b> Same as in D.1.b, D.1.c, D.1.f.vii and F.1.a through F.1.h.</p>
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	<p><b>Compliance:</b> Substantial.</p>
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in F.1.c.</p> <p><b>Findings:</b> Same as in F.1.c.</p> <p><b>Current recommendations:</b> Same as in F.1.c.</p>
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as above.</p>

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		<p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p> <p><b>Current recommendation:</b> Same as above.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as F.1.e.</p>

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		<p><b>Findings:</b> Same as F.1.e.</p> <p><b>Current recommendations:</b> Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Findings:</b> Same as in F.1.d. and F.1.g.</p> <p><b>Current recommendations:</b> Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Findings:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Compliance:</b> Same as in C.2.n, C.2.o and F.1.c.</p> <p><b>Current recommendations:</b> Same as in C.2.n, C.2.o and F.1.c.</p>

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F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice and present supporting documentation.</p> <p><b>Findings:</b> The facility's data indicated that 100% of psychiatrists (46) completed at least 16 hours of psychopharmacology CME.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and present supporting documentation.</p>
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2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p> <p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Alex Guerrero, PsyD, PBS team leader</li> <li>2. Ashvind Singh, PhD , Treatment Enhancement Coordinator</li> <li>3. Darren Sush, PsyD, Coordinator Psychology Specialty Services</li> <li>4. John Lusch, Mall Director</li> <li>5. Karen Chong, Acting Clinical Administrator</li> <li>6. Keven Buckheim, PhD, Psychologist, Assistant Treatment Enhancement Coordinator</li> <li>7. Shawn Johnson, Assistant By Choice Coordinator</li> <li>8. Sheri Greve, PsyD, Acting Chief of Psychology</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The records of the following 35 individuals: APR, BE, BMY, CD, CG, CW, DP, GCB, HC, HCR, HEL, HH, HL, JH, JMT, JR, MC, MCF, MDS, ML, MS, NH, NK, OM, PB, RC, RR, RRC, SH, SM, SRM, TC, TG, VC, and ZC</li> <li>2. Behavior Guideline outcome data graphs</li> <li>3. Behavior Guidelines developed and implemented during this review period</li> <li>4. Completed Psychology Services Monitoring Forms</li> <li>5. Completed Structural and Functional Assessment Instruments (QABF, FAI, QABF-MI, Reinforcement Inventory for Adults)</li> <li>6. ETRC/PSSC meeting dates and minutes</li> <li>7. Focused Psychology Assessments completed during this review period</li> <li>8. List of Cognitive Rehabilitation groups</li> <li>9. List of individuals meeting trigger thresholds during this review period</li> <li>10. List of individuals referred for neuropsychology services</li> <li>11. Mall Group Satisfaction Survey Template</li> <li>12. MSH's Behavior Guideline and PBS Plan Development and</li> </ol>

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		<p>Implementation Procedure Guideline</p> <ol style="list-style-type: none"> <li>13. MSH's Guide to Developing a Milieu Plan</li> <li>14. MSH's Neuropsychological Services Overview and Referral Guidelines</li> <li>15. MSH's Non-Adherence Committee Report</li> <li>16. MSH's Participation in Treatment Questionnaire</li> <li>17. MSH's protocol for evaluating cognitive functioning using observational methods</li> <li>18. PBS Hospital Annual Update Program</li> <li>19. PBS New Employee Orientation Program</li> <li>20. PBS Plan Fidelity Checks</li> <li>21. PBS Plan Outcome Data and Graphs</li> <li>22. PBS Staff Training Logs</li> <li>23. PBS/DCAT Individual Satisfaction Survey</li> <li>24. Positive Behavior Support Hospital Annual Update Presentation</li> <li>25. Positive Behavior Support New Employee Orientation Presentation</li> <li>26. Positive Behavioral Support Plans (PBS)</li> <li>27. Quality Council Report on the Analysis of Violence and Aggression at MSH</li> <li>28. Structural and Functional Assessment Reports</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, Unit 401) for quarterly review of for JH</li> <li>2. WRPC (Program III, Unit 409) for annual review of JMT</li> <li>3. WRPC (Program VI, Unit 419) for monthly review of GCB</li> </ol>
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH does not have the sufficient number of PBS teams to meet the requirement of one team per 300 individuals. At the moment, MSH has</p>

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	<p>professional standards of care, in the following areas:</p>	<p>one PBS team and one incomplete DCAT team. The PBS team does not have a data analyst; currently a student assistant is helping out as a data analyst. However, the facility appears to be meeting the needs of the individuals in its care with this team.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Ensure that all State Hospitals have the required number of Positive Behavior Support teams to meet the 1:300 ratio of teams to individuals.</p>
<p>F.2.a.i</p>	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> PBS team members have continued to receive training on PBS and related areas during this review period, confirmed by documentation review and staff interviews:</p> <ul style="list-style-type: none"> <li>• Three-Day Intensive Positive Behavior Support Seminar</li> <li>• Administering and Scoring the QABF-MI</li> <li>• Aggression and Violence in Mental Hospitals</li> <li>• PBS Plan Summary Process</li> <li>• Behavior Guideline Review</li> <li>• Conducting the Functional Assessment Interview</li> <li>• Review and Analysis of the FAI</li> </ul> <p>The trainings shown above had been provided by the DMH consultants and the facility's experts.</p>

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		<p>PBS staff also trained hospital staff during new employee and annual staff training periods. The topics presented during the staff training were appropriate. The trainers should emphasize on milieu therapy, effect of staff behaviors on individuals, and proactive interventions.</p> <p>The work of the PBS staff has shown improvement as evidenced by the quality of the PBS plans and behavior guidelines developed and implemented during this review period. As a whole, these plans were better than the plans reviewed during the two previous review periods. Most of the plans were of acceptable quality, with a few of them failing to meet the technical and clinical adequacy. Most encouraging is the focus placed on staff training (current training is provided on knowledge scores and performance scores) treatment integrity checks (staff had identified low fidelity scores and retrained staff) and plan revisions (plans had been revised through staff retraining when integrity scores were low, as in the case of SRM). In the past, the PBS staff had failed to recognize treatment fidelity levels and had gone on to modify the interventions without knowing if the problem was due to poor implementation. PBS staff should continue to receive training on comprehensive behavioral assessments and interventions that emphasize predictors and de-escalation/reactive strategies.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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		<p><b>Findings:</b> MSH has a new By Choice incentive program coordinator. The previous Coordinator has left the service.</p> <p>Using the DMH Psychology Monitoring-By Choice Form, MSH assessed its compliance based on a sample of 599 WRPs:</p> <table border="1" data-bbox="993 451 1892 527"> <tr> <td data-bbox="993 451 1087 527">2.</td> <td data-bbox="1087 451 1795 527"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1795 451 1892 527">90%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of least 90% since the previous review period.</p> <p>A review of the records of ten individuals found that all ten of the WRPs reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs (APR, BE, CD, DP, MDS, MS, OM, SH, TG and ZC). The documentation included whether the individual carried a baseline or re-allocated point card with data on points earned. However, in many cases the point re-allocation was not done when in fact there was room for doing so (e.g., decrease in Mall attendance for DP and MS). The teams could have used the 50 points under their control, even if the individual "chose" not to re-allocate the points.</p> <p>This monitor observed three WRPCs (GCB, JH, and JMT). The WRPTs engaged the individuals in the By Choice point allocation process. The teams did not give enough attention to the By Choice point allocation process and procedures to maximize its potential to motivate the individuals in areas of difficulty/poor progress. Teams should hold a better discussion with the individual, if need be outside the WRPC, to help the individual see the need to make some point allocation changes. Furthermore, the teams do not appear to realize that they have 50 points that they can allocate to support the individual's efforts to make</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	90%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	90%			

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progress in certain areas. In addition, Mall group facilitators continue to neglect the verbal/social pairing when presenting the By Choice point cards to the individuals. A sentence or two on how the individual did in the group, what the facilitator recognized most with the individual's participation, what the individual did to earn maximum points, or even thanking the individual for attending the group would be meaningful to the individual.

The following table summarizes staff training on By Choice during the review period (August 2010 - January 2011):

Staff Training in By Choice							
	Aug	Sep	Oct	Nov	Dec	Jan	Mean
Number of staff eligible for training	73	43	54	60	103	108	74
Number of staff trained	73	43	54	60	75	97	67
Percentage of eligible staff trained	100	100	100	100	73	90	94

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, MSH assessed its compliance based on a mean sample of 26% of the Level of Care staff:

1.	<i>Staff understands the goal of the By Choice system</i>	100%
2.	<i>Staff can state the current point cycle</i>	98%
3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	100%
4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%

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		5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	99%
		6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	99%
		7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	98%
		8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	98%
		9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	100%
		10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	99%
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>				
<p><b>Other findings:</b> Using the Fidelity of Implementation by Individuals Form, MSH also assessed fidelity of By Choice implementation based on a total sample of 469 individuals:</p>				
		1.	<i>The individual understands the goal of the By Choice system.</i>	91%
		2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	72%
		3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	97%
		4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	98%
		5.	<i>The individual can state the behavioral criteria for</i>	88%

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			<i>earning an FP, MP, or NP for the current cycle.</i>	
		6.	<i>Individual can indicate how many points he or she may earn each day.</i>	80%
		7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	62%
		8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	61%
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	97%
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% since the previous review period for items 1, 3, 4 and 9 and the following changes in compliance for the remaining items:</p>				
			Previous period	Current period
<b>Mean compliance rate</b>				
		2.	92%	72%
		5.	100%	88%
		6.	99%	80%
		7.	93%	62%
		8.	94%	61%
<p>Using the By Choice Monitoring Form: Satisfaction Check, MSH surveyed a mean sample of 69% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>				
			Previous period	Current period
		1.	<i>By Choice motivates me to participate in treatment</i>	75% 71%
		2.	<i>The point system motivates me to</i>	76% 72%

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			<i>improve my behavior</i>		
		3.	<i>The point system motivates me to learn new skills</i>	72%	70%
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	67%	59%
		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	72%	72%
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	72%	72%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	74%	68%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	72%	68%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	74%	73%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	73%	63%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	80%	82%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	73%	81%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	73%	81%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	70%	82%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	83%	89%
		<p>Using the Fidelity of Implementation by the By Choice Staff Form, MSH further assessed fidelity of implementation based on an average sample of 100% of By Choice staff:</p>			

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		<table border="1"> <tr> <td data-bbox="989 228 1066 337">1.</td> <td data-bbox="1066 228 1774 337"><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units.</i></td> <td data-bbox="1774 228 1871 337">93%</td> </tr> <tr> <td data-bbox="989 337 1066 446">2.</td> <td data-bbox="1066 337 1774 446"><i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i></td> <td data-bbox="1774 337 1871 446">100%</td> </tr> <tr> <td data-bbox="989 446 1066 527">3.</td> <td data-bbox="1066 446 1774 527"><i>The incentive store is well stocked with appropriate items from the incentive list.</i></td> <td data-bbox="1774 446 1871 527">33%</td> </tr> <tr> <td data-bbox="989 527 1066 609">4.</td> <td data-bbox="1066 527 1774 609"><i>The incentive store has an inventory control system to track store inventory and individual preferences.</i></td> <td data-bbox="1774 527 1871 609">100%</td> </tr> <tr> <td data-bbox="989 609 1066 690">5.</td> <td data-bbox="1066 609 1774 690"><i>Individuals have substantive input into the items being offered in the Incentive Store.</i></td> <td data-bbox="1774 609 1871 690">100%</td> </tr> <tr> <td data-bbox="989 690 1066 755">6.</td> <td data-bbox="1066 690 1774 755"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1774 690 1871 755">100%</td> </tr> <tr> <td data-bbox="989 755 1066 836">7.</td> <td data-bbox="1066 755 1774 836"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1774 755 1871 836">100%</td> </tr> <tr> <td data-bbox="989 836 1066 950">8.</td> <td data-bbox="1066 836 1774 950"><i>The incentive store staff has received appropriate training regarding incentive store policies and procedures.</i></td> <td data-bbox="1774 836 1871 950">100%</td> </tr> <tr> <td data-bbox="989 950 1066 1031">9.</td> <td data-bbox="1066 950 1774 1031"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1774 950 1871 1031">93%</td> </tr> <tr> <td data-bbox="989 1031 1066 1096">10.</td> <td data-bbox="1066 1031 1774 1096"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1774 1031 1871 1096">100%</td> </tr> <tr> <td data-bbox="989 1096 1066 1169">11.</td> <td data-bbox="1066 1096 1774 1169"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1774 1096 1871 1169">93%</td> </tr> </table>	1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units.</i>	93%	2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%	3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	33%	4.	<i>The incentive store has an inventory control system to track store inventory and individual preferences.</i>	100%	5.	<i>Individuals have substantive input into the items being offered in the Incentive Store.</i>	100%	6.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%	7.	<i>There is a By Choice Manual located in the incentive store.</i>	100%	8.	<i>The incentive store staff has received appropriate training regarding incentive store policies and procedures.</i>	100%	9.	<i>The individuals bring their point cards to the store to make a purchase.</i>	93%	10.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%	11.	<i>There is an Alert List in the incentive store for staff reference.</i>	93%	
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<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% since the previous review period for all items except item 3, which was 36% in the previous review period. The facility should work to improve the inventory in the By Choice stores.</p> <p>Using the DMH By Choice Implementation Monitoring Forms (Level of</p>																																				

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		<p>Care Staff, Individuals, and By Choice program staff), MSH assessed fidelity of implementation based on average samples of 26% of the Level of Care Staff, 78% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p> <table border="1" data-bbox="993 376 1587 495"> <tr> <td>Level of Care Staff</td> <td>99%</td> </tr> <tr> <td>Individuals</td> <td>83%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>92%</td> </tr> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Level of Care Staff	99%	Individuals	83%	By Choice Program Staff	92%
Level of Care Staff	99%							
Individuals	83%							
By Choice Program Staff	92%							
F.2.b	<p>Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The Acting Chief of Psychology confirmed that she continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>						
F.2.c	<p>Each State Hospital shall ensure that:</p>	<p><b>Compliance:</b> Substantial.</p>						

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F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="991 597 1911 1424"> <tr> <td data-bbox="991 597 1087 711">1.</td> <td data-bbox="1087 597 1795 711"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1795 597 1911 711">100%</td> </tr> <tr> <td data-bbox="991 711 1087 784">2.</td> <td data-bbox="1087 711 1795 784"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1795 711 1911 784">100%</td> </tr> <tr> <td data-bbox="991 784 1087 857">3.</td> <td data-bbox="1087 784 1795 857"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1795 784 1911 857">100%</td> </tr> <tr> <td data-bbox="991 857 1087 971">4.</td> <td data-bbox="1087 857 1795 971"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1795 857 1911 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1084">5.</td> <td data-bbox="1087 971 1795 1084"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1795 971 1911 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1087 1157">6.</td> <td data-bbox="1087 1084 1795 1157"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1795 1084 1911 1157">100%</td> </tr> <tr> <td data-bbox="991 1157 1087 1230">7.</td> <td data-bbox="1087 1157 1795 1230"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1795 1157 1911 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1344">8.</td> <td data-bbox="1087 1230 1795 1344"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1795 1230 1911 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1385">9.</td> <td data-bbox="1087 1344 1795 1385"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1795 1344 1911 1385">100%</td> </tr> <tr> <td data-bbox="991 1385 1087 1424">10.</td> <td data-bbox="1087 1385 1795 1424"><i>Additional functional assessment interviews were</i></td> <td data-bbox="1795 1385 1911 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>Additional functional assessment interviews were</i>	100%
1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%																														
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		<p><i>conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i></p>	
		<p>11. <i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i></p> <p>100%</p> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 10 PBS plans (BMY, CG, CW, HH, JR, MC, ML, SM, SRM and VC) found that all 10 had been developed and implemented based on data derived from structural and functional assessments. The structural and functional assessments reviewed were comprehensive, including all major components necessary to obtain information to build a hypothesis. However, a major weakness among the assessments reviewed is the absence of diagnostic and personality-related variables as part of the structural and functional assessment or analysis. The next step PBS teams should take is to ensure that diagnostic techniques are included as part of a comprehensive functional assessment/analysis. Functional assessment or analysis involves more than determining predictive and consequence factors. Concluding that someone is depressed is not an endpoint of analysis. The next question is to figure out why he/she is depressed (e.g., biological, environmental, or both). What about Axis II disorders (e.g. personality disorders)? A recovery (strengths-based and person-centered) approach should recognize and address these issues during the assessment phase to develop meaningful function-based hypothesis and interventions.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	

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<p>F.2.c.ii</p>	<p>hypotheses of the maladaptive behavior are based on structural and functional assessments;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="991 597 1887 673"> <tr> <td data-bbox="991 597 1087 673">12.</td> <td data-bbox="1087 597 1793 673"><i>Testable data-based hypotheses of the challenging behavior were developed</i></td> <td data-bbox="1793 597 1887 673">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 10 PBS plans (BMY, CG, CW, HH, JR, MC, ML, SM, SRM and VC) found that the hypotheses in all 10 were based on structural and functional assessments and aligned with findings from the structural/functional assessments. This monitor reviewed the raw data on structural and functional assessments and found that the hypothesis of derived were aligned with the data presented. However, in many cases the hypotheses could be strengthened.</p> <p>Clinicians can further improve the quality of their structural and functional assessments by addressing/attending to the following:</p> <ol style="list-style-type: none"> <li>1. Conduct a second order/molecular assessment and analysis of the data. For example, concluding that someone is withdrawn because he/she is depressed is not an endpoint of assessment. The next question to be asked and assessed is why he/she is depressed (e.g., environmental vs biological or both).</li> </ol>	12.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%
12.	<i>Testable data-based hypotheses of the challenging behavior were developed</i>	100%			

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		<p>2. Medical/psychiatric variables should be part of the structural/functional assessment and analysis. An understanding of the distinction and overlap of "behavior" and "symptom" is important. Both should be monitored and analyzed, and accompanied by supportive interventions.</p> <p>3. Resolve explanatory variance/conflict from different sources of information (e.g. chart review, staff interviews, and direct observation or interview of the individual).</p> <p>4. Hypotheses should be written as a complete summary statement composed of the problem behavior, setting event, triggering antecedent, and the maintaining consequence. Writing hypotheses in this format will lead to a more focused and specific function based intervention. A fairly good example can be found in TC (behavior guideline dated 2/21/2011).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="991 1263 1892 1382"> <tr> <td data-bbox="991 1263 1087 1382">5.</td> <td data-bbox="1087 1263 1793 1382"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1793 1263 1892 1382">100%</td> </tr> </table>	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
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		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the structural and functional assessments of six PBS plans (CG, PB, RC, RR, SRM and TC) found that all six had documented and/or included discussion of previous behavioral interventions and their effects.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.iv	<p>behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH reported that the PBS and DCAT teams now focus more on the predictive behaviors (e.g., setting events, triggers/antecedents and precursor behaviors) as part of the structural and functional assessments and utilize the findings as intervention strategies in the PBS plans. This monitor's findings from review of the PBS plans support the facility's report.</p> <p>The PBS/DCAT teams have developed and implemented an Individual Satisfaction Survey, which is administered to individuals participating in a PBS plan. The survey addresses issues important to the individuals being served and is used in the continued assessment and implementation of PBS plans. This monitor's review of a sample of completed surveys found that the individuals had given positive feedback regarding their experience and benefits as a function of the PBS interventions.</p> <p>Using the DMH Psychology Services Monitoring Form, MSH assessed its</p>

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		<p>compliance based on a 100% sample of individuals with new or revised PBS plans and behavior guidelines during the review months (August 2010-January 2011):</p> <table border="1" data-bbox="991 337 1890 451"> <tr> <td data-bbox="991 337 1087 451">17.</td> <td data-bbox="1087 337 1795 451"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i></td> <td data-bbox="1795 337 1890 451">96%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 10 behavior intervention plans (BMY, CG, CW, HH, JR, MC, ML, SM, SRM and VC) found that all 10 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>The plans were generally comprehensive and of acceptable quality. A number of deficiencies were noted in some plans. Clinicians should pay attention to a number of issues to further improve the quality of their plans and to have better outcomes from the interventions. The following should be considered:</p> <ol style="list-style-type: none"> <li>1. Ensure that the use of terminology comports with the scientific field. For example, a "precursor" is a behavior/response by the individual that tends to occur immediately prior to the target behavior. For example, an individual may yell or threaten to engage in aggression before engaging in aggression. The precursors are signs and signals that act as a warning that the more severe target behavior is imminent. It is not the same as the usage in some plans (e.g., as found in the plan for CG). Misapplication can adversely impact the focus of interventions.</li> <li>2. Attend to motivational operations. Most plans do not address this factor. The unit is a dynamic setting, and many events "out of</li> </ol>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	96%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	96%			

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		<p>routine" could impact the target behavior (e.g., sleep, medication including time taken, meal delay, staff/peer changes, etc.). Clinicians should conduct a debriefing with the staff responsible for implementing the plan at the episode and the individual (if possible) to identify the motivational operations. For example, Functional Assessment Interview (11/21/10) on ED showed that "sleeps through the night for the most part, but she has had times where she was awake." It would be of clinical relevance to know if she was awake during the night on the date she assaulted someone.</p> <ol style="list-style-type: none"> <li>3. Ensure that there is alignment between and among the setting events, antecedents, and precursors identified and the educational, preventive, and reactive strategies recommended.</li> <li>4. The facility may want to consider placing general strategies that would be of benefit to all individuals under a separate section, for example "educational/general guideline" and not under the "prevention" section.</li> <li>5. Ensure that behavior plans are written at the reading/comprehension level of the staff implementing the plan, and have a plan implementation sheet (or what sometimes is termed as a "cheat sheet") written in a bulleted fashion under the various intervention strategy sections for the staff to refer to, as opposed to the whole 5-10 page written plan. The whole plan can be in the individual's chart and the plan implementation sheet in a file on the nursing station.</li> <li>6. Write reactive strategies in a meaningful way. Statement such as "redirect" as a method of de-escalation is insufficient for the staff to know the specific ways of carrying out such strategies without details unique to the individual or situation. A fairly good example of writing reactive strategies can be found in ED's PBS plan (12/10).</li> </ol> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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<p>F.2.c.v</p>	<p>behavioral interventions are consistently implemented across all settings, including school settings;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Documentation review and staff interview found that the PBS team members have conducted competency-based training with staff responsible for implementing the intervention plans, and conducted re-training using role-playing as part of the competency-based training procedures.</p> <p>Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of new or revised PBS plans or behavior guidelines during the review months (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed 10 PBS plans (CG, HC, HH, JR, MC, ML, NK, PB, RR and RRC). All plans had one or more fidelity checks conducted. Clinicians have made significant improvements in tracking and analyzing plan implementation. This effort has helped clinicians to identify poor implementation and take appropriate corrective strategies through retraining staff (e.g., CG). These and other related tasks will be adversely affected unless the facility hires to fill the vacant positions in the PBS/DCAT teams, and ensures that PBS/DCAT nursing members do not have demands that will impact their PBS/DCAT-related tasks. The stress might already be felt in that the Acting Clinical Director had to take action by restructuring and reassigning PBS team members to address the needs of certain areas/units where the need is greater.</p>
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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																																																																																																
<p>F.2.c.vi</p>	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</p> <table border="1" data-bbox="991 711 1906 1172"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th></th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>5</td> <td>3</td> <td>9</td> <td>6</td> <td>5</td> <td>7</td> <td>5.8</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Seclusion</td> <td>2</td> <td>0</td> <td>1</td> <td>4</td> <td>1</td> <td>1</td> <td>1.5</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>1:1</td> <td>13</td> <td>13</td> <td>19</td> <td>22</td> <td>25</td> <td>24</td> <td>18.2</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Aggression to others</td> <td>28</td> <td>24</td> <td>22</td> <td>22</td> <td>32</td> <td>33</td> <td>27</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Aggression to self</td> <td>16</td> <td>10</td> <td>10</td> <td>14</td> <td>14</td> <td>15</td> <td>13</td> </tr> <tr> <td>%C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>As the table above shows, the PSSC/PBS teams have reviewed all cases of triggers with maladaptive behaviors on the key indicators. MSH has made tremendous progress in the area of tracking, monitoring, and evaluating the trigger data for further behavioral assessment and intervention. It is encouraging, finally, to see that the PBS team members are coordinating pharmacological and behavioral interventions</p>	DMH Psychology Services Monitoring Form									Aug	Sep	Oct	Nov	Dec	Jan	Mean	Restraint	5	3	9	6	5	7	5.8	%C	100%	100%	100%	100%	100%	100%	100%	Seclusion	2	0	1	4	1	1	1.5	%C	100%	100%	100%	100%	100%	100%	100%	1:1	13	13	19	22	25	24	18.2	%C	100%	100%	100%	100%	100%	100%	100%	Aggression to others	28	24	22	22	32	33	27	%C	100%	100%	100%	100%	100%	100%	100%	Aggression to self	16	10	10	14	14	15	13	%C	100%	100%	100%	100%	100%	100%	100%
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		<p>with this population. The PBS team members have moved away from the notion that behavioral supports are not necessary when a person has a mental illness diagnosis and is on medication. An understanding of the distinction and overlap of "behavior" and "symptom" is important. Both require ongoing monitoring, analysis, and supportive interventions. Exclusive focus on medication becomes a problem when it leads to a neglect of other supportive interventions. The PBS team coordination with the medicine/psychiatry team members for individuals with medically/psychiatrically related challenging behaviors and the positive outcome from that coordination was obvious from the data presented at the Risk Management case review meeting.</p> <p>This monitor reviewed records of 16 individuals who had triggered on one or more key indicators (CW, HC, HH, HL, JR, MC, ML, NH, NK, PB, RC, RR, SM, SRM, TC and VC). In all cases, the individual's behaviors had been reviewed at various levels following the Risk Management procedure and appropriate assessments had been carried out and where appropriate intervention plans had been developed and implemented.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.vii	<p>positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (August 2010-January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review</p>

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		<p>period.</p> <p>A review of eight behavioral intervention plans (HL, JR, NH, PB, RC, RR, SRM and TC) found that all eight contained documentation indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern. The interaction of therapies with other treatment modalities needs further refinement. Communication with other disciplines alone is insufficient unless the information is incorporated into the assessment and intervention phases.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="993 1117 1892 1230"> <tr> <td data-bbox="993 1117 1087 1230">19.</td> <td data-bbox="1087 1117 1795 1230"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1795 1117 1892 1230">85%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals with PBS plans or PBS</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	85%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	85%			

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		<p>assessments (CG, CW, HC, HCR, HEL, HH, JR, MC, MCF, ML, NK, PB, RRC, SM, SRM, TC and VC) found that all 17 of the WRPs in the charts had properly discussed the PBS plan in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP. The entries in the Present Status sections had data when available, except for the newly implemented plans (e.g. HH).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="993 971 1892 1045"> <tr> <td data-bbox="993 971 1087 1045">24.</td> <td data-bbox="1087 971 1793 1045"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1793 971 1892 1045">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals with PBS plans (T CG, CW, HC, HCR, HEL, HH, JR, MC, MCF, ML, NK, PB, RRC, SM, SRM, TC and VC) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in 16 records. The documentation was not comprehensive for HEL.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>						
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of behavior guidelines developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="993 673 1890 787"> <tr> <td data-bbox="993 673 1087 787">20.</td> <td data-bbox="1087 673 1795 787"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1795 673 1890 787">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of PBS plans developed or revised during the review period (August 2010-January 2011):</p> <table border="1" data-bbox="993 1084 1890 1161"> <tr> <td data-bbox="993 1084 1087 1161">21.</td> <td data-bbox="1087 1084 1795 1161"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1795 1084 1890 1161">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of staff training data for nine behavioral intervention plans (CG, HL, JR, NH, PB, RC, RR, SRM and TC) found that competency-based staff training had been conducted for all nine cases. Clinicians have made</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						

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		<p>significant improvement in staff training procedures, now including performance-based training (role-playing, modeling, etc) in addition to the previous knowledge-based training (ask, answer orally, answer written questions). This monitor, with the collaboration of the Acting Chief of Psychology, interviewed staff on selected PBS plans for individuals on the unit. In all three cases, the staff interviewed were able to state the main elements in the individual's PBS plan.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility reported that all PBS team members are primarily responsible for the provision of behavioral interventions, providing 30 hours per week of PBS-related duties on assigned units. Most of the PBS team members facilitate one PSR Mall group weekly during their assigned work hours. The PBS staff are assigned to regular shifts and mandatory overtime on the units any time there is a need. The facility should guard against regression in the timeliness, quality and quantity of PBS work. In addition, PBS staff need time to develop and implement proactive interventions and conduct milieu therapy and staff training in addition to their usual behavioral assessments and interventions, along with facilitating Mall groups.</p> <p><b>Current recommendation:</b> Ensure that all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions.</p>

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F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.2.a.ii.</p> <p><b>Findings:</b> See F.2.a.ii.</p> <p><b>Current recommendations:</b> See F.2.a.ii.</p>
F.2.d	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH does not have a full DCAT team. According to the Acting Chief of Psychology, the team is short three members: a clinical psychologist, a social worker, and a data analyst.</p> <p>According to the Acting Chief of Psychology, both the PBS and DCAT team positions were lost in January 2011 due to budgetary issues outside of the facility's control. The Acting Chief of Psychology also stated that an applicant has been interviewed for the SW position. The PBS team is temporarily using the services of a student assistant for data analysis. Documentation review found that the current members of the DCAT team are facilitating Mall groups, in addition to conducting assessments and developing and implementing behavioral intervention plans.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Ensure that each State hospital has at least one developmental and cognitive abilities team</p>
F.2.e	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The PSSC has participated collaboratively with the ETRC at the PSSC/ETRC meetings to review cases with the respective unit staff/WRPTs and address their concerns. A review of the PSSC/ETRC meeting minutes found that the meetings had been held regularly with high attendance. This monitor suggests that the PSSC meet separately, at a minimum bi-weekly, in addition to the current PSSC/ETRC meeting. There is not enough time during the PSSC/ETRC meeting for a comprehensive behavioral case review, discussion of the various aspects of the procedures and processes involved in the particular case and review of data/graph and intervention strategies. This time can be gainfully used to teach/train unit psychologists and other direct care staff. Medical/psychiatry, and staff from other disciplines if relevant, should be invited to attend these PSSC meetings</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.f	<p>Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological</p>	<p><b>Current findings on previous recommendation:</b></p>

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	<p>assessment of individuals with persistent mental illness.</p>	<p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance as follows:</p> <table border="1" data-bbox="991 451 1881 824"> <thead> <tr> <th></th> <th></th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>22</td> <td>12</td> <td>16</td> <td>5</td> <td>7</td> <td>10</td> <td>12</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>6</td> <td>6</td> <td>4</td> <td>5</td> <td>4</td> <td>5</td> <td>5</td> </tr> <tr> <td>18.a. iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>51 days</td> </tr> </tbody> </table> <p>The number of referrals for neuropsychological assessments doubled from an average of six per month during the previous review period to an average of 12 per month during the current period. By the same token, the mean time to completion increased from 23 days during the previous period to 51 days during this review period. According to the Acting Chief of Psychology, the department has gone through reorganization and will ensure that neuropsychological referrals are addressed more promptly. The department has conducted training and guidelines for referral.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			Aug	Sep	Oct	Nov	Dec	Jan	Mean	18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	22	12	16	5	7	10	12	18.a. ii	<i>Of those in 18.a.i, number completed</i>	6	6	4	5	4	5	5	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							51 days
		Aug	Sep	Oct	Nov	Dec	Jan	Mean																														
18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	22	12	16	5	7	10	12																														
18.a. ii	<i>Of those in 18.a.i, number completed</i>	6	6	4	5	4	5	5																														
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							51 days																														

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F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Psychologists at MSH continue to have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Aubri Griffis, Nursing Coordinator, CNS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Nursing Services Monitoring PRN Audit summary data, August 2010 - January 2011</li> <li>2. MSH Nursing Services Monitoring Stat Audit summary data, August 2010 - January 2011</li> <li>3. MSH Nursing Staff Familiarity Monitoring Audit summary data, August 2010 - January 2011</li> <li>4. MSH Medical Transfer Audit summary data, August 2010 - January 2011</li> <li>5. MSH Nursing Services Audit summary data, August 2010 - January 2011</li> <li>6. MSH Medication Administration Monitoring Audit summary data, August 2010 - January 2011</li> <li>7. 50 Medication Variance forms for the review period</li> <li>8. MSH's training rosters</li> <li>9. Medication Observation form from facility nurse observer</li> <li>10. Medical records for the following 40 individuals: ACR, AER, AIZ, BMY, CG, DEK, DT, DYH, EJB, EL, EPA, FCR, HQY, JC, JEM, JG, JJJ, JMP, JNN, KL, KKK, KSD, KTR, LAB, MAF, MCF, MN, NSM, RCC, SEG, SH, SM, SML, SP, SS, TC, TCE, TLH, WMV and YAS</li> <li>11. The medical records of 12 individuals who were transferred to outside hospitals for acute care during this review period: AR, CAG, CW, DG, EN, IB, JC, JP, JZP, LT, RTP and SP</li> </ol>

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		<p><b>Observed:</b></p> <ol style="list-style-type: none"> <li>1. WRPC (Program II, unit 412) for monthly review of MCL</li> <li>2. WRPC (Program II, unit 416) for monthly review of WMV</li> <li>3. WRPC (Program VI, unit 419) for annual review of SB</li> <li>4. Shift report on Program VI, Unit 419</li> <li>5. Medication administration on Unit 409</li> </ol>
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	<p><b>Compliance:</b> Substantial.</p>
F.3.a.i	safe administration of PRN medications and Stat medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least</p>

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		<p>90% from the previous review period.</p> <p>A review of 260 PRN and Stat orders (200 PRN and 60 Stat) for 40 individuals (ACR, AER, AIZ, BMY, CG, DEK, DT, DYH, EJB, EL, EPA, FCR, HQY, JC, JEM, JG, JNL, JMP, JNN, KL, KLK, KSD, KTR, LAB, MAF, MCF, MN, NSM, RCC, SEG, SH, SM, SML, SP, SS, TC, TCE, TLH, WMV and YAS) found 258 included specific individual behaviors. In addition, all notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in all notes.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1044 1887 1193"> <tr> <td data-bbox="991 1044 1087 1193">3.</td> <td data-bbox="1087 1044 1793 1193"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 1044 1887 1193">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 200 incidents of PRN medications for 28 individuals (ACR, AER, AIZ, BMY, CG, DEK, EJB, EL, EPA, FCR, JEM, JMP, JNN, KL, KSD,</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%			

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		<p>LAB, MAF, MN, NSM, RCC, SEG, SH, SM, SML, TCE, TLH, WMV and YAS) found adequate documentation in the IDNs of the circumstances requiring the PRN in 197 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="993 526 1892 675"> <tr> <td data-bbox="993 526 1087 675">4.</td> <td data-bbox="1087 526 1797 675"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1797 526 1892 675">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 60 incidents of Stat medications for 23 individuals (AER, AIZ, BNY, DT, DYH, FCR, HQY, JC, JG, JJJ, JMP, KL, KKK, KTR, MCF, NSM, SEG, SP, SS, TC, TLH, WMV and YAS) found adequate documentation in the IDNs of the circumstances requiring the Stat in all incidents.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	99%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed</p>			

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		<p>its compliance based on a 24% mean sample of PRNs administered each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 305 1892 415"> <tr> <td data-bbox="991 305 1087 415">5.</td> <td data-bbox="1087 305 1795 415"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1795 305 1892 415">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 200 incidents of PRN medications for 28 individuals (ACR, AER, AIZ, BMY, CG, DEK, EJB, EL, EPA, FCR, JEM, JMP, JNN, KL, KSD, LAB, MAF, MN, NSM, RCC, SEG, SH, SM, SML, TCE, TLH, WMV and YAS) found a timely comprehensive assessment in the IDNs of the individual's response in 197 incidents.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, MSH also assessed its compliance based on a 25% mean sample of Stat medications administered each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 971 1892 1081"> <tr> <td data-bbox="991 971 1087 1081">6.</td> <td data-bbox="1087 971 1795 1081"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1795 971 1892 1081">98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 60 incidents of Stat medications for 23 individuals (AER, AIZ, BNY, DT, DYH, FCR, HQY, JC, JG, JJJ, JMP, KL, KKK, KTR, MCF, NSM, SEG, SP, SS, TC, TLH, WMV and YAS) found a timely comprehensive assessment in the IDNs of the individual's response in all incidents.</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	98%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	99%						
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	98%						

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.b	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> A review of 50 MVRs found that MSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue current practice.</p>			
<p>F.3.d</p>	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Staff Familiarity Monitoring Audit, MSH assessed its compliance based on an average sample of 23% of the nursing staff:</p> <table border="1" data-bbox="991 673 1892 824"> <tr> <td data-bbox="991 673 1087 824">8.</td> <td data-bbox="1087 673 1795 824"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1795 673 1892 824">92%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In all three WRPCs observed by this monitor, all team members were very familiar with the individual and the individual's goals and interventions in the WRPs. Specifically, the RN from the PBS team who was present at the WRP for MCL demonstrated extensive knowledge of the individual and obviously had developed a significant therapeutic relationship with her. Also, from conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p><b>Compliance:</b> Substantial.</p>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	92%
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	92%			

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>F.3.e</p>	<p>Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that audits regarding nursing documentation for change in status address the quality of the documentation.</li> <li>• Audit change of status requirement by first reading the "story" regarding the change of status, which may begin days prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation and then score the monitoring tool.</li> <li>• Collaborate with the Facility's Nurse Practitioners to teach and mentor to build and improve nursing competency regarding changes in status.</li> </ul> <p><b>Findings:</b> Since the last review, the Medical Transfer Audits are being completed by the CNS RN/NC to ensure that the audits regarding nursing documentation for change in status accurately address the quality of the documentation. In addition, MSH had developed Reference for Assessment and Notification (RAN) binders for all units.</p> <p><b>Recommendation 4, September 2010:</b> Ensure that audits addressing change of shift report accurately reflect the shift report observed.</p> <p><b>Findings:</b> In September 2010, the Nursing monitors and mentors were trained on new criteria focusing on quality improvement for change of shift reports. The completed audits for shift report are given to the Program Nursing Coordinators for follow-up and feedback.</p>

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		<p><b>Recommendation 5, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Transfer Audit, MSH assessed its compliance based on a 89% sample of individuals transferred to community hospitals each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 485 1892 711"> <tr> <td data-bbox="991 485 1087 597">1.</td> <td data-bbox="1087 485 1793 597"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 485 1892 597">84%</td> </tr> <tr> <td data-bbox="991 597 1087 711">7.</td> <td data-bbox="1087 597 1793 711"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 597 1892 711">71%</td> </tr> </table> <p>The compliance rates for both items were reported to be 96% in the previous review period.</p> <p>The Department of Nursing reported that they have identified this area as in need of significant improvement. During the week of February 28-March 4, 2011, Nursing "Boot Camp" training was held for Psychiatric Technicians and Registered Nurses addressing issues and documentation pertaining to Change of Shift and Medical Emergencies. In the event of a medical emergency, an RN/HSS will assist the unit RN with all necessary assessments and documentation. In addition, the CNS Department will review the records of individuals experiencing a medical emergency to ensure that all assessments were completed and documented. A review of the emergency with the CNS Department and Program NC will be held on the first business day after the incident and will include a review of the documentation for a month prior to the change of status,</p> <p>A review of the records of 12 individuals who were transferred to a community hospital/emergency room (AR, CAG, CW, DG, EN, IB, JC, JP,</p>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	84%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	71%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	84%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	71%						

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		<p>JZP, LT, RTP and SP) found a number of problematic issues with the nursing documentation. Examples of problematic issues included:</p> <p><u>Change in Status</u></p> <ul style="list-style-type: none"><li>• Nurses not recognizing symptoms that warrant assessments and regular follow-up as changes in status.</li><li>• The lack of neurological checks and mental status documented for individuals with a significant change in cognition.</li><li>• Inconsistencies found regarding when the Change of Status Forms are to be initiated.</li></ul> <p><u>Nursing Assessments</u></p> <ul style="list-style-type: none"><li>• No nursing assessment conducted for an individual noted to be in a "silent state" and not following commands.</li><li>• No nursing assessment documented for an individual's report of upper body shakes lasting for 30 seconds.</li><li>• No nursing assessment documented for an individual demonstrating an unsteady gait. No nursing documentation or assessment for 10 hours from the onset of symptoms up to the time the individual was sent to community hospital.</li><li>• No nursing assessments documented for complaints of pain.</li><li>• No assessments of bowel sounds and palpation of the abdomen found when PRNs given for episodes of constipation.</li><li>• Individual was noted to have oxygen saturation of 86%; no complete nursing assessment documented that included vital signs and lung sounds.</li><li>• Incomplete assessments of an individual having seizure activity.</li><li>• Lack of follow-up assessments for symptoms of constipation.</li><li>• Lack of a complete nursing assessment upon return to the facility addressing the symptoms that precipitated the hospitalization or ER visit.</li></ul>
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		<p><u>Documentation</u></p> <ul style="list-style-type: none"> <li>• Lack of documentation regarding appropriate assessments of individuals at the time of the onset of symptoms to establish a baseline.</li> <li>• Significant gaps in documentation after individuals were identified as experiencing a change in status.</li> <li>• Lack of adequate documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room.</li> <li>• Difficult to determine exactly when an individual was actually transferred to community hospital/emergency room.</li> <li>• A number of Change of Status forms noted assessments were conducted by a check mark; however, there was no documentation of the results of the assessments.</li> <li>• No consistent summary documented of treatments provided at the community hospital or ER.</li> <li>• Some Change of Status forms were illegible.</li> <li>• Illegible progress notes and signatures and titles.</li> <li>• A significant number of progress notes that were documented out of order.</li> </ul> <p>These findings do not comport with MSH data. The interventions that MSH has implemented as noted above should assist the facility in identifying more accurately the problematic issues that have been consistently found in this area. From a discussion with the auditor for this area, she reported that she had begun reviewing the documentation two to four weeks prior to the date the individual was transferred to a community emergency room or hospital, which should also assist in identifying issues regarding conducting and documenting appropriate nursing assessments. As noted above, the auditing process for this area has been reviewed to generate accurate data regarding this area. The facility has significant work to do in this area so that the individuals are provided timely and appropriate nursing assessments and</p>
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		<p>interventions, and to ultimately attain substantial compliance with this requirement.</p> <p>Using the DMH Nursing Services Audit, MSH assessed its compliance based on a 100% sample of Change of Shift Reports observed during in the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 451 1890 565"> <tr> <td data-bbox="991 451 1087 565">10.</td> <td data-bbox="1087 451 1795 565"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1795 451 1890 565">96%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit 419 found that the report included some clinical information but was basically generic and included no association with the individuals' symptoms in relation to their Axis diagnoses or specific clinical information indicating if the individuals were doing better or worse regarding their symptoms. The facility needs to continue its efforts in mentoring appropriate shift reports.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that audits regarding nursing documentation for change in status address the quality of the documentation.</li> <li>2. Continue training and strategies focused on building and improving nursing competency regarding assessments and documentation addressing changes in status.</li> <li>3. Ensure that audits addressing change of shift report accurately reflect the shift report observed.</li> <li>4. Continue efforts in mentoring appropriate shift reports to include</li> </ol>	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	96%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	96%			

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		<p>clinically relevant information related to the Axis diagnoses.</p> <p>5. Continue to monitor this requirement.</p>
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p><b>Compliance:</b> Substantial.</p>
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that staff who administer medications are trained to deal appropriately with agitated individuals.</li> <li>• Ensure that staff are aware of individual procedures for medication administration.</li> </ul> <p><b>Findings:</b> In response to these recommendations, MSH indicated that staff training rosters were tracked in the CNS office to ensure that all required staff attends the annual Therapeutic Strategy Intervention class, which addresses dealing with agitated individuals, and the Nursing Annual Update class, which addresses the policy and procedure for medication administration. There was no indication that any type of corrective action was implemented regarding the incident observed and described in the previous report.</p> <p><b>Recommendation 3, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 98%. Comparative data indicated</p>

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		<p>that MSH has maintained a compliance rate of at least 90% from the previous review period. Compliance rates for other items in this audit are reported in the following cells.</p> <p>From observations of medication administration on Unit 409, the unit had recently implemented the use of two medication nurses in attempts to increase the time nurses have to administer medications and improve the interactions regarding medication education with the individuals during medication administration. The medication nurse observed demonstrated some interaction with the individuals receiving medications and provided some medication education. All medication administration procedures were appropriately followed. Also, the facility nurse observing the medication administration provided feedback and correction when appropriate.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue implementation of medication administration strategies to increase therapeutic interactions between medication nurses and individuals during medication administration.</li> <li>2. Continue to monitor this requirement.</li> </ol>
F.3.f.ii	education is provided to individuals during medication administration;	The facility reported a mean compliance rate of 95%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	The facility reported a mean compliance rate of 99%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide retraining to staff addressing the need to document the</li> </ul>

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		<p>medication, dosage, route and time administered for PRNs and Stat medications on the Medication Administration Record.</p> <ul style="list-style-type: none"> <li>• Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice.</li> </ul> <p><b>Findings:</b> In January 2011, MSH appropriately revised Nursing Policies 528 and 530 to include the time on the Medication Administration Record for all PRN and Stat medications.</p> <p><b>Recommendation 3, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medication Administration Monitoring Audit, MSH assessed its compliance based on an average sample of 28% of level of care nursing staff who are licensed and medication-certified, and reported a mean compliance rate of 97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>MSH was able to produce MVRs for the blanks that were found and reported on the MTRs and Narcotic Logs during the review period. The facility continues to put in efforts in analyzing the medication administration system to evaluate strategies to ensure that medication nurses have the time they need to appropriately administer medications and interact with the individuals during medication administration.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically	<b>Current findings on previous recommendation:</b>

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	<p>justified reasons.</p>	<p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> A review of the records of an individual on unit 419 found that he had been rendered bed-bound since admission to MSH on February 2, 2011 because his custom wheelchair was not transferred with him from his previous placement. His WRP dated 2/15/2011 indicated that he had been spending most of his time in bed and was waiting for a physical therapy evaluation for an appropriate chair. The staff on his unit reported that he is always in bed since they do not have an appropriate chair into which he can be safely transferred. A review of the facility's intra-office requisitions indicated that his chair and a bed bolster were not ordered until 3/1/2011. Consequently, he remained bed-bound due to the lack of available adaptive equipment. In addition, this situation had not been reported to facility administration until found by the monitoring team.</p> <p>Although significantly delayed, the facility developed an Action Plan during the review week that included the following interventions:</p> <ul style="list-style-type: none"> <li>• Develop a 24-hour Support Plan;</li> <li>• Consult with Fairview Developmental Center PT/OT;</li> <li>• Bolsters and wedges will be used to prevent entrapment and to elevate head of bed;</li> <li>• Maintain constant monitoring/supervision;</li> <li>• Re-locate to a room closer to the nursing station;</li> <li>• Provide range of motion, cognitive orientation, rehabilitation; and</li> <li>• The executive team will receive a daily report on individual's status.</li> </ul> <p><b>Compliance:</b> Noncompliance.</p>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement interventions outlined in the Action Plan and document outcomes.</li> <li>2. Develop and implement a system to ensure that equipment issues do not render individuals bed-bound.</li> <li>3. Ensure that all bed-bound individuals are timely reviewed and findings communicated with facility administration.</li> <li>4. Continue to monitor this requirement.</li> </ol>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p><b>Compliance:</b> Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH training rosters indicated that all required staff attended and passed the required training.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.3.h.ii.</p>

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		<p><b>Current recommendation:</b> Continue current practice.</p>
F.3.h.iii	positive behavior support principles.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.3.h.ii.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH training rosters indicated that 100% of all existing staff attended and passed the required training.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrea Ciota, Assistant Chief of Rehabilitation Therapy</li> <li>2. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>3. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>4. Rebecca McClary, Acting Supervising Rehabilitation Therapist</li> <li>5. Renee Kelly, Chief of Rehabilitation Therapy</li> <li>6. Ruth N. Flores, Supervisor for Vocational Services</li> <li>7. Terez Henson, Supervising Rehabilitation Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 audit data for August 2010 - January 2011</li> <li>2. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review</li> <li>3. Records of the following 20 individuals participating in observed PSR Mall groups: AG, CB, CL, EF, GAC, JHM, JLS, JRM, KEP, MS, NK, PD, PLB, RAJ, RAM, RGA, SC, SM, VF and WS</li> <li>4. List of individuals who received direct physical therapy services from August 2010 - January 2011</li> <li>5. List of individuals who received direct speech therapy services from August 2010 - January 2011</li> <li>6. List of individuals who received direct occupational therapy services from August 2010 - January 2011</li> <li>7. Records of the following eight individuals who received direct physical therapy, speech therapy and occupational therapy services from August 2010 - January 2011: BE, EFL, GEF, IB, JDF, JP, JR and LT</li> <li>8. List of individuals with a 24-Hour Rehabilitation Support Plan</li> <li>9. Records of the following seven individuals with 24-Hour Rehabilitation Support Plans: AD, BE, DC, EL, JP, JR and LB</li> <li>10. List of individuals with INPOP plans</li> </ol>

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		<p>11. Records for the following three individuals with INPOP plans: BE, MPB and PW</p> <p>12. Records for the following two individuals at high risk for falls: FR and PD</p> <p>13. Records for the following two individuals who had three or more falls in 30 days or a fall with a major injury during the review period: EWVC and MLC</p> <p>14. Records for the following three individuals at high risk for impaired skin integrity, or with a decubitus diagnosis: JJW, JP and TW</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Mural Painting PSR Mall group</li> <li>2. IT Horticulture PSR Mall group</li> <li>3. Retail and Merchandising PSR Mall group</li> <li>4. Music and Movement PSR Mall group</li> <li>5. Project Return PSR Mall group</li> <li>6. Creative Expression PSR Mall group</li> <li>7. Court Competency PSR Mall group</li> </ol>
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	Please see subcells for compliance findings.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b></p> <p>During the maintenance period, work to improve the quality and consistency of POST documentation, as well as to ensure that individuals who are at high risk for falls and decubitus are optimally protected from harm by receiving timely therapy services as clinically indicated.</p>

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		<p><b>Findings:</b> See D.4.a and F.4.c. for findings regarding this recommendation.</p> <p>The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during the week of January 24-28:</p> <table border="1" data-bbox="989 451 1587 605"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>16</td> <td>14</td> </tr> <tr> <td>OT</td> <td>41</td> <td>33</td> </tr> <tr> <td>SLP</td> <td>4</td> <td>4</td> </tr> </tbody> </table> <p>The facility reported that the main reason for variances between scheduled and provided sessions was individual refusals.</p> <p>Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 29% of individuals receiving speech, occupational, and/or physical therapy direct treatment during the review period August 2010 - January 2011, and reported a mean compliance rate of 97%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals receiving direct occupational, physical and speech therapy treatment to assess compliance with F.4.a.i criteria found seven records in substantial compliance (BE, EFL, GEF, IB, JP, JR and LT) and one record in partial compliance (JDF).</p> <p>In terms of individualized outcomes, record review found that five out of eight individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes.</p> <p><b>Compliance:</b> Substantial.</p>		Scheduled	Provided	PT	16	14	OT	41	33	SLP	4	4
	Scheduled	Provided												
PT	16	14												
OT	41	33												
SLP	4	4												

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> During the maintenance period, continue to work to ensure that all individuals who would benefit from this service (including individuals outside of the SNF unit) are referred for and receive this service if clinically indicated.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 29% of plans completed during the review period (August 2010 - January 2011) and reported a mean compliance rate of 97%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals with INPOP programs found that all three records were in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p>

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		<p><b>Findings:</b> The facility reported that 92 out of 102 nurses (90%) who required training related to the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency. Details of training and training subjects were not provided.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation 1, September 2010:</b> During the maintenance period, ensure that all individuals who require a 24-hour support plan to promote safety and independence are provided with this service, and that 24-hour plans contain adequate detail to inform staff of supports and techniques necessary to promote maximum function and safety.</p> <p><b>Findings:</b> The facility reported that the rehabilitation therapy department developed a priority system in order to identify individuals who would benefit from a 24-hour support plan.</p> <p>A review of the records of individuals who were at high risk for falls, choking and aspiration, impaired skin integrity and/or met fall triggers or had an incident of decubitus found that only one individual out of six who appeared to meet criteria for a 24-hour support plan had evidence of this service being implemented. Two individuals (EWVC and MLC) were referred for physical and/or occupational therapy evaluations (with</p>

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		<p>potential plan development) but refused.</p> <p>Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals with 24-hour support plans during the review period August 2010 - January 2011, and reported a mean compliance rate of 87%. Comparative data indicated that MSH exhibited a decrease in compliance from 95% in the previous review period.</p> <p>A review of records of seven individuals with 24-hour support plans to assess compliance with F.4.c criteria found two records in substantial compliance (DC and JR) and five records in partial compliance (AD, BE, EL, JP and LB). Overall plan content related to self-care and mealtime improved, though sections related to communication, positioning and mobility were not consistently completed in a clinically meaningful manner to address risks and promote function.</p> <p><b>Recommendation 2, September 2010:</b>          During the maintenance period, work to improve integration of information pertaining to RT PSR Mall group services into the treatment plan, progress notes, and Present Status section of the WRP.</p> <p><b>Findings:</b>          The facility reported that a training to address documentation in the Present Status section of the WRP was developed and provided to 34 rehabilitation therapists (as verified by review of training rosters). However, it is not clear how many rehabilitation therapists required this training.</p> <p>Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 10% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period August 2010 - January 2011,</p>
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and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.

A review of the records of 20 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 15 records in substantial compliance (AG, CB, CL, EF, JHM, JLS, JRM, NK, PD, PLB, RAJ, RAM, RGA, SC and SM) and five records in partial compliance (GAC, KEP, MS, VF and WS).

In terms of individualized outcomes, record review found that eight out of 20 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes.

Observation of seven PSR Mall groups found that in all groups observed, a lesson plan was in use and all groups appeared to provide activities that were in line with the individuals' assessed needs.

The table below presents the number of scheduled and actual hours of PSR mall hours provided by RT and Vocational Rehabilitation staff during the week of January 24-28:

	Scheduled	Provided
RT	431	316
Voc Rehab	42	26

The facility reported that variance between hours scheduled and hours provided was due to staffing limitations.

**Compliance:**  
Partial.

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Improve and enhance current practice.</li> <li>2. Continue to monitor this requirement.</li> </ol>															
F.4.d	<p>Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database and 90% of individuals with adaptive equipment each month during the review period August 2010 - January 2011:</p> <table border="1" data-bbox="989 784 1885 1162"> <tr> <td>e.</td> <td><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td>100%</td> </tr> <tr> <td>f.</td> <td><i>The individual was provided with the equipment as per the doctor's order</i></td> <td>100%</td> </tr> <tr> <td>g.</td> <td><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td>100%</td> </tr> <tr> <td>h.</td> <td><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td>100%</td> </tr> <tr> <td>i.</td> <td><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate greater than 90% from the previous review period.</p> <p><b>Compliance:</b> Substantial.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%															
f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%															
g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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		<b>Current recommendation:</b> Continue to monitor this requirement.
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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Denise Manos, Director of Nursing Services</li> <li>2. Mary Ramirez, Assistant Director of Nutrition Services (Food Production)</li> <li>3. Portia Salvacion, Assistant Director of Nutrition Services (Clinical)</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from August 2010 - January 2011 for each assessment type</li> <li>2. Records of the following 30 individuals with types a-j.ii assessments from August 2010 - January 2011: AH, AIZ, AMM, CA, CBS, CDS, CFR, CMG, EA, FDPA, FPR, GA, GCB, JJ, JLR, JP, JS, LEP, LH, LMA, LT, MD, OAR, SCG, SDK, SL, SM, SR, SSG and TDR</li> <li>3. Meal Accuracy Report audit data from August 2010 - January 2011</li> <li>4. Nutrition Care Monitoring Tool audit data from August 2010 - January 2011 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types)</li> <li>5. List of individuals at risk for choking and aspiration</li> <li>6. Records for the following four individuals at risk for choking or aspiration: JLC, JRL, LW and RAJ</li> <li>7. List of individuals with a new diabetes diagnosis during the review period</li> <li>8. Records for the following three individuals with a new diabetes diagnosis of diabetes during the review period: JJF, SO and SRM</li> <li>9. List of individuals at risk for metabolic syndrome</li> <li>10. Records for the following three individuals at high risk for metabolic syndrome: CCK, CM and KMS</li> <li>11. Records for the following individuals receiving enteral nutrition: ALM and EA</li> </ol>

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		<p><u>Observed:</u> The following individuals with 24-hour support plans during lunch on unit 419: DC, EL and JP</p> <p><u>Toured:</u> Food Services and Production areas</p>						
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 32% of Nutrition Assessments (all types) due each month from August 2010 - January 2011 (total of 72 out of 222):</p> <table border="1" data-bbox="989 894 1887 1045"> <tr> <td data-bbox="989 894 1087 932">7.</td> <td data-bbox="1087 894 1776 932"><i>Nutrition education is documented.</i></td> <td data-bbox="1776 894 1887 932">100%</td> </tr> <tr> <td data-bbox="989 932 1087 1045">8</td> <td data-bbox="1087 932 1776 1045"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1776 932 1887 1045">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 30 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p> <p>The facility reported that according to Meal Accuracy report data, 12%</p>	7.	<i>Nutrition education is documented.</i>	100%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%
7.	<i>Nutrition education is documented.</i>	100%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	100%						

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		<p>of trays audited were verified as 99% accurate in terms of diet prescription and therapeutic diets. However, while cooks, food service technicians and level of care staff currently provide three levels of verification to determine that therapeutic diet textures (puree, mechanical soft, chopped) are accurate, staff have not been trained on diet texture identification.</p> <p><b>Other findings:</b> A review of records for three individuals at high risk for metabolic syndrome and three individuals with a new diagnosis of diabetes found that all six records contained evidence of a nutrition assessment that addressed risk factors, contributing factors, and clinical recommendations, with reassessment administered in accordance with assigned acuity level. However the Nutrition assessment for one individual (SO) did not address glucose levels.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Provide standard competency-based training to cooks, food service technicians and level of care staff on identification of therapeutic diet textures (e.g., puree, mechanical soft, chopped).</li> </ol>
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance with WRP integration based on an average sample of 32% of</p>

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		<p>Nutrition Assessments (all types) due each month from August 2010 - January 2011 (72 out of 222):</p> <table border="1" data-bbox="989 302 1885 492"> <tr> <td data-bbox="989 302 1087 378">19.</td> <td data-bbox="1087 302 1776 378"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1776 302 1885 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 492">20.</td> <td data-bbox="1087 378 1776 492"><i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i></td> <td data-bbox="1776 378 1885 492">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 30 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	100%	20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	99%
19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	100%						
20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	99%						
F.5.c	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> No cases of aspiration pneumonia were reported during the current or previous review period, though it appears that at least one individual (ALM) had an incident during these periods. The current reporting system does not appear to be designed to easily query and identify</p>						

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		<p>choking incidents.</p> <p>Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p><b>Other findings:</b> A review of the records of four individuals at high risk for choking and aspiration found that two of four (JRL and LW) were assessed by a speech therapist with subsequent recommendations for interventions for modified diets and safe swallowing strategies. One of these individuals (JRL) did not have adequate interventions to support safe eating as he appeared to require positioning supports during meals and snacks, but a 24-hour support plan to address this issue had not been developed or implemented. One individual (JLC) did not have choking risk addressed in his WRP, nor documentation of referral to SLP and for one individual (RAJ) it appeared that SLP assessment was not clinically indicated, as he was stable and on a modified diet.</p> <p>Three individuals (DC, EL and JP) who required mealtime interventions and 24-hour support plans due to risk of aspiration and choking were observed during mealtime, and it was noted that optimal supports were partially implemented for all three individuals.</p> <p>A choking task force was developed in response to an unexpected death of an individual due to choking. However, the task force does not have representation from a therapist (e.g., speech therapist, occupational therapist) who is competent in assessing and treating issues related to eating and swallowing. This is reportedly due to limited staff resources.</p> <p><b>Compliance:</b> Partial.</p>
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		<p><b>Current recommendation:</b> Continue to improve and enhance current practice.</p>
F.5.d	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> The facility reported that both dietitians who required training in Dysphagia Screening and Assessment were trained to competency on 8/19/10.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.5.e	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to improve and enhance current practice.</p> <p><b>Findings:</b> A review of the records of two individuals who are NPO (ALM and EA) found no evidence of reassessment to provide continued justification and/or determination of whether the individual would be appropriate for return to oral intake. It was reported that these individuals were assessed quarterly by the SLP, but no progress note documentation was found in the record for EA, and only partial documentation was found for ALM.</p>

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		<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Ensure that individuals who are NPO are reassessed quarterly or as clinically indicated, and that findings are documented in the WRP.</p>
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6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	As of the tour conducted in September 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	

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7. General Medical Services		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Adella Davis-Sterling, Supervising RN, Medical Services</li> <li>2. Arza Izadian, MD, Neurology Consultant</li> <li>3. Chi Vu, MD, Physician and Surgeon</li> <li>4. Hani Benyamin, MD, Physician and Surgeon</li> <li>5. Leonard Liu, MD, Physician and Surgeon</li> <li>6. Niza Uy-Uyan, MD, Physician and Surgeon</li> <li>7. Quynh Pham, MD, Physician and Surgeon</li> <li>8. Teneese Nguyen, MD, Physician and Surgeon</li> <li>9. Thai Vu, MD, Physician and Surgeon</li> <li>10. Zakaria Boshra, MD, Chief Physician and Surgeon</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following nine individuals who were transferred to an outside medical facility during the review period: AR, CW (three transfer events), EN, JC, JP (three transfer events), JP-2, IB, LT (two transfer events), and SP (two transfer events)</li> <li>2. The charts of the following 12 individuals: CBB, CH, DJG, FR, GWA, HMT, JL, JN, MEB, MMS, MPR and WO</li> <li>3. Medicine Quarterly Assessment Note on the following eight individuals: AR, JG, JM, JT, LK, MJA, TE, and TW</li> <li>4. Mortality Review reports of unexpected deaths for the following three individuals: HF, IIG, and OS</li> <li>5. List of all individuals admitted to external hospitals during the review period</li> <li>6. DMH Medical Surgical Progress Note auditing summary data (August - January 2010/2011)</li> <li>7. DMH Medical Transfer auditing summary data (August - January 2010/2011)</li> <li>8. DMH Medical Emergency Response auditing summary data (August -</li> </ol>

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		<p>January 2010/2011)</p> <ol style="list-style-type: none"> <li>9. DMH Medical Emergency Response Drill auditing summary data (August - January 2010/2011)</li> <li>10. DMH Integration of Medical Conditions into the WRP auditing summary data (August - January 2010/2011)</li> <li>11. MSH Required Documentation from Outside Consultations/Hospitals summary data (August - January 2010/2011)</li> <li>12. DMH Diabetes Mellitus auditing summary data (August - January 2010/2011)</li> <li>13. DMH COPD/Asthma auditing summary data (August - January 2010/2011)</li> <li>14. DMH Hypertension auditing summary data (August - January 2010/2011)</li> <li>15. DMH Dyslipidemia auditing summary data (August - January 2010/2011)</li> <li>16. MSH Preventative Care auditing summary data (August - January 2010/2011)</li> <li>17. MSH Cardiac Disease auditing summary data (January 2011)</li> <li>18. MSH Metabolic Syndrome auditing summary data (August - January 2010/2011)</li> <li>19. Number of PCPs re-privileged current review period and previous review period</li> <li>20. Flowchart for Stable Metro Swallower Patients - revised 2/17/11 (revisions highlighted)</li> <li>21. Two PBS Plans for CW; 9/09 and 9/10</li> <li>22. Template Critical Value Communication Log</li> <li>23. Schedule of after hours medical and psychiatric coverage</li> <li>24. MSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators:             <ul style="list-style-type: none"> <li>• Diabetes Mellitus</li> <li>• Dyslipidemia</li> <li>• Obesity</li> <li>• Hypertension</li> </ul> </li> </ol>
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		<ul style="list-style-type: none"> <li>• Bowel Dysfunction</li> <li>• Falls</li> <li>• Aspiration Pneumonia (clinical outcome only)</li> <li>• Seizure Disorder (clinical outcome only)</li> <li>• Specialty Consultations (process outcome only)</li> <li>• Unexpected Mortalities (process and clinical outcomes)</li> </ul>
F.7.a	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Implement corrective actions to address the monitor's findings of deficiencies.</li> <li>• Improve facility administrative oversight to ensure timely and appropriate immediate systemic corrective measures in the context of the initial mortality reviews.</li> </ul> <p><b>Findings:</b></p> <p>During this review period, the facility implemented a variety of corrective actions, including actions to address the findings of deficiencies listed in the previous report. The following is a summary of the facility's actions:</p> <ol style="list-style-type: none"> <li>1. The requirement to perform a complete post-fall assessment on individuals who suffer falls was discussed with physicians and surgeons and nursing staff, and compliance was being monitored using the current audit tools.</li> <li>2. In cooperation with the Department of Psychology, a new WRP Non-Adherence Protocol, which requires all refusals of medical or dietary interventions for three times to be individually evaluated by the psychologist using a standardized screening/assessment tool, was implemented. This tool, which includes functional assessment, addresses the reasons for refusals and assists in developing the proper interventions. In addition, the Chief of Forensic Psychiatry</li> </ol>

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		<p>provided a lecture to all physicians to address the legal and bioethical aspects of non-adherence to recommended treatment.</p> <p>3. A Metabolic Syndrome weekly clinic was started for individuals with that diagnosis. The clinic, run by an MSH cardiologist, is tasked with the proper management of those individuals who are at particular risk of serious morbidities or death due to cardiovascular disease.</p> <p><b>Other findings:</b>          This monitor reviewed the charts of individuals who were transferred to an outside medical facility on 16 occasions during this reporting period. The monitor also interviewed physicians and surgeons involved in the care of these individuals. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 743 1875 1409"> <thead> <tr> <th>Individual</th> <th>Date/time of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>8/20/10</td> <td>Seizure Disorder</td> </tr> <tr> <td>2</td> <td>8/20/10</td> <td>Ingestion of Foreign Body</td> </tr> <tr> <td>3</td> <td>8/27/10</td> <td>Volume depletion, Hypokalemia and Renal Insufficiency</td> </tr> <tr> <td>2</td> <td>8/27/10</td> <td>Abdominal Pain</td> </tr> <tr> <td>2</td> <td>9/15/10</td> <td>Recurrent Abdominal Pain</td> </tr> <tr> <td>3</td> <td>9/22/10</td> <td>Hypertension</td> </tr> <tr> <td>4</td> <td>9/25/10</td> <td>Fecal Impaction</td> </tr> <tr> <td>5</td> <td>9/30/10</td> <td>Hyponatremia and Urinary Tract Infection</td> </tr> <tr> <td>6</td> <td>10/7/10</td> <td>Seizure Disorder</td> </tr> <tr> <td>6</td> <td>10/14/10</td> <td>Altered Level of Consciousness</td> </tr> <tr> <td>6</td> <td>10/18/10</td> <td>Seizure Disorder</td> </tr> <tr> <td>7</td> <td>10/25/10</td> <td>Seizure Disorder</td> </tr> <tr> <td>7</td> <td>11/1/10</td> <td>Seizure Disorder</td> </tr> </tbody> </table>	Individual	Date/time of MD evaluation	Reason for transfer	1	8/20/10	Seizure Disorder	2	8/20/10	Ingestion of Foreign Body	3	8/27/10	Volume depletion, Hypokalemia and Renal Insufficiency	2	8/27/10	Abdominal Pain	2	9/15/10	Recurrent Abdominal Pain	3	9/22/10	Hypertension	4	9/25/10	Fecal Impaction	5	9/30/10	Hyponatremia and Urinary Tract Infection	6	10/7/10	Seizure Disorder	6	10/14/10	Altered Level of Consciousness	6	10/18/10	Seizure Disorder	7	10/25/10	Seizure Disorder	7	11/1/10	Seizure Disorder
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		5	11/12/10	Seizure Disorder
		8	12/7/10	Altered Level of Consciousness
		9	1/22/11	Intractable Vomiting
		<p>The review found general of evidence that MSH has maintained an adequate system of timely medical assessments and care.</p> <p>This monitor found the following process deficiencies:</p> <ol style="list-style-type: none"> <li>1. The physician's assessment upon the return transfer of an individual who was hospitalized for recurrent abdominal pain (and found to have pancreatitis) did not address any factors that may have contributed to this condition (CW).</li> <li>2. The nursing reassessment of an individual who reportedly had unsteady gait was inadequate (IB).</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that the assessment of individuals upon return from outside hospitalization includes a review of the factors contributing to the diagnoses that were established during outside hospitalization (particularly when these conditions were not predictable based on the individual's course at MSH).</li> <li>2. Consider CME activity (for both nursing and medical staff) dedicated to understanding and management of delirium.</li> </ol>		
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.		

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<p>F.7.b.i</p>	<p>require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Surgical Progress Notes Auditing Form, MSH assessed its compliance based on an average sample of 13% of all individuals with at least one diagnosis on Axis III during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 597 1887 1010"> <tr> <td data-bbox="991 597 1087 672">1.</td> <td data-bbox="1087 597 1793 672"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1793 597 1887 672">98%</td> </tr> <tr> <td data-bbox="991 672 1087 824">2.</td> <td data-bbox="1087 672 1793 824"><i>There is appropriate identification of conditions for which the individual is at risk, and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 672 1887 824">98%</td> </tr> <tr> <td data-bbox="991 824 1087 1010">3.</td> <td data-bbox="1087 824 1793 1010"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 824 1887 1010">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	98%	2.	<i>There is appropriate identification of conditions for which the individual is at risk, and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	98%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.</i>	99%
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<p>F.7.b.ii</p>	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Medical Transfer Auditing Form, MSH assessed its compliance based on an average sample of 90% of medical transfers during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 560 1890 1421"> <tr> <td data-bbox="991 560 1081 673">1.</td> <td data-bbox="1081 560 1795 673"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1795 560 1890 673">84%</td> </tr> <tr> <td data-bbox="991 673 1081 820">2.</td> <td data-bbox="1081 673 1795 820"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1795 673 1890 820">90%</td> </tr> <tr> <td data-bbox="991 820 1081 901">3.</td> <td data-bbox="1081 820 1795 901"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1795 820 1890 901">90%</td> </tr> <tr> <td data-bbox="991 901 1081 1047">4.</td> <td data-bbox="1081 901 1795 1047"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1795 901 1890 1047">95%</td> </tr> <tr> <td data-bbox="991 1047 1081 1193">5.</td> <td data-bbox="1081 1047 1795 1193"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1795 1047 1890 1193">99%</td> </tr> <tr> <td data-bbox="991 1193 1081 1339">6.</td> <td data-bbox="1081 1193 1795 1339"><i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></td> <td data-bbox="1795 1193 1890 1339">97%</td> </tr> <tr> <td data-bbox="991 1339 1081 1421">7.</td> <td data-bbox="1081 1339 1795 1421"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency</i></td> <td data-bbox="1795 1339 1890 1421">80%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	84%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	90%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	90%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	95%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	99%	6.	<i>Timely written progress notes by the regular medial physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i>	97%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency</i>	80%
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		<table border="1" data-bbox="989 191 1890 232"> <tr> <td data-bbox="989 191 1087 232"></td> <td data-bbox="1087 191 1793 232"><i>room treatment.</i></td> <td data-bbox="1793 191 1890 232"></td> </tr> </table> <p data-bbox="989 272 1890 415">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 2 through 6. The compliance rates for items 1 and 7 were 95% and 99% respectively in the previous review period.</p> <p data-bbox="989 456 1890 600">MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 16% of the average monthly census during the review period (August 2010 - January 2011). The following is a summary of the data:</p> <table border="1" data-bbox="989 641 1890 1276"> <tr> <td data-bbox="989 641 1087 711">1.</td> <td data-bbox="1087 641 1793 711"><i>All medical conditions listed in Axis III are included on the Medical Conditions form</i></td> <td data-bbox="1793 641 1890 711">95%</td> </tr> <tr> <td data-bbox="989 711 1087 781">2.</td> <td data-bbox="1087 711 1793 781"><i>The WRP includes each medical condition listed on the Medical Conditions form</i></td> <td data-bbox="1793 711 1890 781">97%</td> </tr> <tr> <td data-bbox="989 781 1087 850">3.</td> <td data-bbox="1087 781 1793 850"><i>There is an appropriate focus statement for each medical condition or diagnosis</i></td> <td data-bbox="1793 781 1890 850">92%</td> </tr> <tr> <td data-bbox="989 850 1087 920">4.</td> <td data-bbox="1087 850 1793 920"><i>There is an appropriate objective for each medical condition or diagnosis</i></td> <td data-bbox="1793 850 1890 920">96%</td> </tr> <tr> <td data-bbox="989 920 1087 990">5.</td> <td data-bbox="1087 920 1793 990"><i>There are appropriate intervention(s) for each objective</i></td> <td data-bbox="1793 920 1890 990">95%</td> </tr> <tr> <td data-bbox="989 990 1087 1060">6.</td> <td data-bbox="1087 990 1793 1060"><i>Each state hospital shall ensure that interdisciplinary teams, review, assess and develop strategies to overcome individuals refusals of medical procedures</i></td> <td data-bbox="1793 990 1890 1060">92%</td> </tr> <tr> <td data-bbox="989 1060 1087 1130">7.</td> <td data-bbox="1087 1060 1793 1130"><i>Each state hospital shall ensure that interdisciplinary teams review, assess and develop strategies to overcome individuals refusals to participate in dental appointments</i></td> <td data-bbox="1793 1060 1890 1130">93%</td> </tr> </table> <p data-bbox="989 1317 1890 1386">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>		<i>room treatment.</i>		1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	95%	2.	<i>The WRP includes each medical condition listed on the Medical Conditions form</i>	97%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis</i>	92%	4.	<i>There is an appropriate objective for each medical condition or diagnosis</i>	96%	5.	<i>There are appropriate intervention(s) for each objective</i>	95%	6.	<i>Each state hospital shall ensure that interdisciplinary teams, review, assess and develop strategies to overcome individuals refusals of medical procedures</i>	92%	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess and develop strategies to overcome individuals refusals to participate in dental appointments</i>	93%
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		<p>Using the same form, MSH assessed its compliance based on a sample of 100% of actual medical emergencies (total of 50), including but not limited to code blue events, during the review period (August 2010 - January 2011):</p>
1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%
3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A
5.	<i>Did the first responder provide appropriate BFA procedures?</i>	100%
6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	100%
7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
8.	<i>Did the MD respond within 15 minutes?</i>	100%
9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	95%
10.	<i>Was the unit milieu appropriately managed?</i>	98%
11.	<i>Was all required equipment available?</i>	100%
12.	<i>Was all required equipment in working order?</i>	100%
13.	<i>Were all medical supplies available?</i>	100%
14.	<i>Were all medications available?</i>	100%
15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%
16.	<i>Did all the staff perform according to assigned roles?</i>	99%
17.	<i>Was staff competent in operating equipment?</i>	100%
18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%

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	19.	<i>Was EMS able to access the site in a timely manner?</i>	100%
	20.	<i>Was all required documentation completed?</i>	98%
	21.	<i>Was the equipment restocking completed within 8 hours?</i>	100%
	<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Using the DMH Medical Emergency Response Evaluation, MSH assessed its compliance based on 85 drills performed during the review period (August 2010 - January 2011):</p>		
	1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
	2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%
	3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
	4.	<i>Did the first responder provide Heimlich procedures?</i>	100%
	5.	<i>Did the first responder provide appropriate BFA procedures?</i>	100%
	6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	N/A
	7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
	8.	<i>Did the MD respond within 15 minutes?</i>	99%
9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	100%	
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11.	<i>Was all required equipment available?</i>	100%	
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		<table border="1"> <tr> <td>13.</td> <td><i>Were all medical supplies available?</i></td> <td>99%</td> </tr> <tr> <td>14.</td> <td><i>Were all medications available?</i></td> <td>100%</td> </tr> <tr> <td>15.</td> <td><i>Was the overall response organized in a manner that led to the best outcome for the individual?</i></td> <td>100%</td> </tr> <tr> <td>16.</td> <td><i>Did all the staff perform according to assigned roles?</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Was staff competent in operating equipment?</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Was the announcement "Code Blue" timely and clear?</i></td> <td>100%</td> </tr> <tr> <td>19.</td> <td><i>Was all required documentation completed?</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>Was EMS able to access the site in a timely manner?</i></td> <td>100%</td> </tr> <tr> <td>21.</td> <td><i>Was the equipment restocking completed within 8 hours?</i></td> <td>98%</td> </tr> </table>	13.	<i>Were all medical supplies available?</i>	99%	14.	<i>Were all medications available?</i>	100%	15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%	16.	<i>Did all the staff perform according to assigned roles?</i>	100%	17.	<i>Was staff competent in operating equipment?</i>	100%	18.	<i>Was the announcement "Code Blue" timely and clear?</i>	100%	19.	<i>Was all required documentation completed?</i>	100%	20.	<i>Was EMS able to access the site in a timely manner?</i>	100%	21.	<i>Was the equipment restocking completed within 8 hours?</i>	98%	<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>Subsequent to the tour, this monitor requested the facility's explanation of the fact that the compliance rates for the emergency drills were implausible and asked for an outline of issues that were identified during the evaluation of the drills that required performance improvement. In response, the facility reported that the Emergency Response Task Group reviewed the Emergency Response Drill data through February 2011. When the facility compared these results with the data of Actual Emergencies as well as outcomes from MIRC case reviews, the level of compliance was not sustained. Analysis indicated that the Emergency Response Drill auditing procedures required improvement.</p> <p>The facility reported the following concerns and corresponding corrective actions that were identified during review of the medical emergency data (actual emergencies and drills) through the MIRC process:</p>
13.	<i>Were all medical supplies available?</i>	99%																												
14.	<i>Were all medications available?</i>	100%																												
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		Area of concern	Corrective actions
		Documentation of emergency response	Nursing Assignment sheets will indicate specific staff responsibilities during emergency response (implemented 3/16/2011).
		Administration of oxygen	In-service training specific to oxygen administration to be provided (implemented 3/28-4/11/2011).
		Utilization of AED	Utilize the training AED and mannequin as part of the emergency drill scenario. (implemented effective 03/5/2011).
		Finger sweep of oral cavity	Implement (every six months) CPR brief updates/reviews to address changes occurring between the bi-annual certification requirements.
		<p>In addition to the above information, the facility reported the following corrective actions:</p> <ol style="list-style-type: none"> <li>1. Unannounced emergency drills will be conducted (the first drill took place already), with the goal of completing fifteen unannounced drills by the end of 2011.</li> <li>2. Mannequins are being utilized for the unannounced drills to simulate actual emergency scenarios and to monitor performance competencies.</li> <li>3. Clinical scenarios for the emergency drills were developed based on actual emergencies and audit reviews of both actual and drill responses.</li> <li>4. In addition to the DMH audit forms, which are being utilized for both actual and drill emergencies, MSH adopted a CPR-specific audit form</li> </ol>	

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		<p>developed by the American Heart Association (AHA) to be completed when CPR is applied to improve the review of staff competencies.</p> <ol style="list-style-type: none"> <li>5. Actual emergency responses will be audited and reviewed by the Chief Physician &amp; Surgeon and the Nursing Coordinator within 24 hours of the incident.</li> <li>6. Regular and unannounced emergency drill audits will be reviewed by the Chief Physician &amp; Surgeon and the Nursing Coordinator on a monthly basis.</li> <li>7. Drills will include CPR instructors as event observers.</li> </ol> <p><b>Other findings:</b>  A review of records of 12 individuals (CBB, CH, DJG, FR, GWA, HMT, JL, JN, MEB, MMS, MPR and WO) who refused an appointment found that five records contained documentation of the refusals in the Present Status section of the WRPs and six included an open focus addressing refusals but were not individualized and were basically the same template. From discussions with the Acting Chief of Psychology and Enhancement Plan Coordinator, the facility did not have a consistent system in place addressing refusals. These findings do not comport with MSH data regarding item 6 in the DMH Integration of Medical Conditions into the WRP Audit (92%).</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Provide a summary narrative of all items identified during the medical emergency response (actual emergencies and drills) as requiring performance improvement and the corresponding corrective actions.</li> <li>3. Continue implementing and formalize facility-wide systems addressing and tracking non-adherence issues.</li> <li>4. Ensure that WRPs addressing refusals are individualized, and address</li> </ol>
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		the reason for refusals.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to utilize SO 136 and the MSH policy on Providing Medical Care to Individuals to define duties and responsibilities of the Primary Care Physicians.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continues to maintain both a psychiatrist and medical physician available at all times after hours.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

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<p>F.7.b.v</p>	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to provide data related to whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility.</p> <p><b>Findings:</b> The facility presented data based on a review of a 100% sample of individuals returning from outside medical treatment during the review period (August 2010 - January 2011). The review tracked whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b> This monitor's chart reviews (see F.7.a) found that necessary records from outside hospitals were available in all cases reviewed</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to provide data related to whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility.</p>
<p>F.7.c</p>	<p>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate,</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>

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modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.

**Findings:**

MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia, asthma/COPD and metabolic syndrome. The average samples were 17% (diabetes mellitus), 16% (hypertension), 15% (dyslipidemia), 15% (COPD/asthma) and 20% (metabolic syndrome) of individuals diagnosed with these disorders during the review months (August 2010 - January 2011). The following tables summarize the facility's data:

Diabetes Mellitus

1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	100%
2.	<i>HgbA1C was ordered quarterly.</i>	100%
3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%
4.	<i>Blood sugar is monitored regularly.</i>	100%
5.	<i>Urinary micro albumin is monitored annually.</i>	100%
6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	N/A
7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%
8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.</i>	99%
9.	<i>Blood pressure is monitored weekly.</i>	100%
10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	100%
11.	<i>An eye exam by an ophthalmologist/optometrist was completed at least annually.</i>	100%
12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	100%

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		<table border="1"> <tr> <td data-bbox="991 191 1087 266">13.</td> <td data-bbox="1087 191 1797 266"><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td data-bbox="1797 191 1898 266">100%</td> </tr> <tr> <td data-bbox="991 266 1087 305">14.</td> <td data-bbox="1087 266 1797 305"><i>Diabetes is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1797 266 1898 305">100%</td> </tr> <tr> <td data-bbox="991 305 1087 383">15.</td> <td data-bbox="1087 305 1797 383"><i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1797 305 1898 383">100%</td> </tr> </table>	13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%	14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	100%	15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	100%
13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%									
14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	100%									
15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	100%									
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p>											
<p><u>Hypertension</u></p>											
1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%									
2.	<i>Blood pressure is monitored weekly.</i>	100%									
3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	98%									
4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	92%									
5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	100%									
6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	100%									
7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	100%									
8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	100%									
9.	<i>An exercise program has been initiated.</i>	100%									
10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%									

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Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.

Dyslipidemia

1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%
2.	<i>A lipid panel was ordered at least quarterly.</i>	100%
3.	<i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i>	100%
4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%
5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	100%
6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	100%
7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	100%
8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	100%
9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	100%
10.	<i>An exercise program has been initiated.</i>	100%
11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	100%

Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.

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		<p><u>Asthma/COPD</u></p> <table border="1"> <tr> <td data-bbox="989 264 1087 341">1.</td> <td data-bbox="1087 264 1793 341"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 264 1890 341">100%</td> </tr> <tr> <td data-bbox="989 341 1087 417">2.</td> <td data-bbox="1087 341 1793 417"><i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i></td> <td data-bbox="1793 341 1890 417">100%</td> </tr> <tr> <td data-bbox="989 417 1087 529">3.</td> <td data-bbox="1087 417 1793 529"><i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i></td> <td data-bbox="1793 417 1890 529">100%</td> </tr> <tr> <td data-bbox="989 529 1087 641">4.</td> <td data-bbox="1087 529 1793 641"><i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i></td> <td data-bbox="1793 529 1890 641">100%</td> </tr> <tr> <td data-bbox="989 641 1087 683">5.</td> <td data-bbox="1087 641 1793 683"><i>Asthma or COPD is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1793 641 1890 683">100%</td> </tr> <tr> <td data-bbox="989 683 1087 760">6.</td> <td data-bbox="1087 683 1793 760"><i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i></td> <td data-bbox="1793 683 1890 760">100%</td> </tr> <tr> <td data-bbox="989 760 1087 802">7.</td> <td data-bbox="1087 760 1793 802"><i>The individual has been assessed for a flu vaccination.</i></td> <td data-bbox="1793 760 1890 802">100%</td> </tr> <tr> <td data-bbox="989 802 1087 906">8.</td> <td data-bbox="1087 802 1793 906"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1793 802 1890 906">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Metabolic Syndrome</u></p> <table border="1"> <tr> <td data-bbox="989 1127 1087 1239">1.</td> <td data-bbox="1087 1127 1793 1239"><i>Waist circumference = or &lt; 40 inches for men or 35 inches for women OR There is an appropriate plan of care in place to address abdominal obesity</i></td> <td data-bbox="1793 1127 1890 1239">100%</td> </tr> <tr> <td data-bbox="989 1239 1087 1351">2.</td> <td data-bbox="1087 1239 1793 1351"><i>Triglycerides: = or &lt; 150 mg/dL (last test result) OR There is an appropriate plan of care in place to address triglycerides</i></td> <td data-bbox="1793 1239 1890 1351">100%</td> </tr> <tr> <td data-bbox="989 1351 1087 1427">3.</td> <td data-bbox="1087 1351 1793 1427"><i>HDL Cholesterol: = or &gt; 40 mg/dL for men or 50 for women (last test result) OR There is an appropriate</i></td> <td data-bbox="1793 1351 1890 1427">100%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	100%	2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	100%	3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	100%	4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	100%	5.	<i>Asthma or COPD is addressed in focus 6 of the WRP.</i>	100%	6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	100%	7.	<i>The individual has been assessed for a flu vaccination.</i>	100%	8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	100%	1.	<i>Waist circumference = or &lt; 40 inches for men or 35 inches for women OR There is an appropriate plan of care in place to address abdominal obesity</i>	100%	2.	<i>Triglycerides: = or &lt; 150 mg/dL (last test result) OR There is an appropriate plan of care in place to address triglycerides</i>	100%	3.	<i>HDL Cholesterol: = or &gt; 40 mg/dL for men or 50 for women (last test result) OR There is an appropriate</i>	100%
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			<i>plan of care in place to address abnormal HDL</i>	
		4.	<i>Blood Pressure: = or &lt; 130/85 mm Hg. (last measurement) OR There is an appropriate plan of care in place to address hypertension</i>	100%
		5.	<i>Fasting Glucose: = or &lt;100 mg/dL OR There is an appropriate plan of care in place to address fasting glucose</i>	100%
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>In addition, MSH conducted audits to assess Cardiac Disease (n=48, sample size unspecified) and Preventive Care (100% sample of individuals receiving annual physicals) using the MSH standardized Cardiac Disease and Preventive Care Audit tools. The following is a summary of the data:</p> <p><u>Cardiac Disease</u></p>				
		1.	<i>Did the patient receive CAD symptom and activity assessment?</i>	100%
		2.	<i>Did the patient receive at least one lipid profile in last year?</i>	100%
		3.a	<i>If LDL&gt;100, did the Individual receive lipid-lowering therapy during the reporting year (diet/exercise/medication)?</i>	100%
		3.b	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	83%
		4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	96%
		5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	70%
		6.	<i>Was antiplatelet therapy prescribed?</i>	100%
		7.	<i>Was beta blocker prescribed after MI or contraindication documented?</i>	100%
		8.	<i>Was ACE inhibitor (or ARB) prescribed?</i>	100%

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Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items except 3.b and 5, which were 100% and 84% respectively in the previous review period.

Preventive Care

1.	<i>If the individual indicated that he/she is a smoker on the Admission Medical H&amp;P, has Smoking Cessation Medical Assistance been initiated, as documented in a psychiatric Progress Note within the previous 6 months and/or on the WRP, including documentation of each of the following: advising the patient to quit smoking, discussion of cessation medication and discussion of smoking cessation strategies?</i>	100%
2.	<i>If the patient has a BMI &gt;27, has weight loss prevention assistance been initiated, as documented in a psychiatric Progress note within the previous 6 months and/or on the most recent WRP, including each of the following: a dietary consult, restricted caloric diet, discussion of physical activity and advising physical activity?</i>	100%
3.	<i>If the individual is 50 or older or is medically debilitated, has the individual been offered a flu shot in the past year as documented on the Preventive Care Tracking Form?</i>	100%
4	<i>If the individual is 50 or older, was the individual offered an influenza immunization during the previous September through February as documented on the Preventive Care Tracking Form? (Mark NA if the individual was not at MSH during that period)</i>	100%
5.	<i>If the individual is 65 or older, has a Pneumonia vaccine been offered or is there documentation that</i>	100%

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			<i>the individual has previously had one, as documented on the Preventive Care Tracking Form?</i>	
		6.	<i>If the individual is a woman age 50 or older or has a family history of breast cancer as indicated on the Admission H&amp;P, has a mammogram been ordered within the past year as documented on the Preventive Care Tracking Form?</i>	100%
		7.	<i>If the individual is age 50 or older, has colorectal cancer screening been done as evidenced by documentation on the Preventive Care Tracking Form of one of the following four items having been done or ordered: (1) fecal occult blood test during the past year, (2) flexible sigmoidoscopy during the past four years, (3) double contrast barium enema during the past four years or (4) colonoscopy during the past nine years?</i>	100%
		8.	<i>If the individual is a woman age 21 or older, has a Pap smear been done within the previous two years as documented on the Preventive Care Tracking Form?</i>	100%
		9.	<i>If the individual is a woman age 16 or older, has one chlamydia tests been done/ordered within the previous year as documented on the Preventive Care Tracking Form?</i>	100%
		9.	<i>If the individual is a woman 65 or older, has osteoporosis testing been done as evidenced by a bone density test during the previous year as evidenced on the Preventive Care Tracking Form?</i>	100%
		Comparative data indicated that the facility has maintained compliance rates of at least 90% since the last review period for all items.		

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.7.d	<p>Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 3, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Provide summary regarding status of implementation of the reprivileging process, including specific information about the performance indicators and percentage of providers who were reassessed using these indicators.</li> <li>• Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</li> </ul> <p><b>Findings:</b> During this review period, seven physicians and surgeons were reprivileged. This number represented 100% of physicians and surgeons who were scheduled for reprivileging as per the facility's policy. The performance indicators were as follows:</p> <ol style="list-style-type: none"> <li>1. Timeliness and completeness of all Admission, Quarterly and Annual assessments;</li> <li>2. Appropriateness and follow-up on all Diagnostic work-up ordered;</li> <li>3. Timeliness and appropriateness of all transfers to outside facilities for hospitalization or ER visits;</li> <li>4. Timeliness and completeness of Transfer and Acceptance notes to and from outside facilities;</li> <li>5. Legibility and accuracy of all notes including progress notes and physician's orders;</li> <li>6. Adequate Committee attendance; and</li> <li>7. Completion of required Continuing Medical Education (CME).</li> </ol>

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		<p>MSH refined its peer review forms by adding more operational items for each indicator regarding the admission/annual physical assessment, the quarterly notes and the problem-oriented progress notes/assessments upon transfer to outside facilities. Reviewing 20% of the charts of individuals cared for at the facility, MSH audited the quality of medical care and reported the following:</p> <table border="1" data-bbox="991 483 1890 714"> <tr> <td data-bbox="991 483 1087 561">1.</td> <td data-bbox="1087 483 1793 561"><i>Admission/Annual Physical Assessments: (Timeliness, Completeness and Quality)</i></td> <td data-bbox="1793 483 1890 561">99%</td> </tr> <tr> <td data-bbox="991 561 1087 639">2.</td> <td data-bbox="1087 561 1793 639"><i>Quarterly Notes; (Timeliness, Completeness and Quality)</i></td> <td data-bbox="1793 561 1890 639">96%</td> </tr> <tr> <td data-bbox="991 639 1087 714">3.</td> <td data-bbox="1087 639 1793 714"><i>Progress/Transfer/Acceptance Notes: (Timeliness, Completeness and Quality)</i></td> <td data-bbox="1793 639 1890 714">100%</td> </tr> </table> <p>The facility reported that it intends to complete this audit once every six months for each unit and for every medical doctor.</p> <p>No comparative data were reported for this audit because it was initiated during this review period.</p> <p><b>Recommendation 2, September 2010:</b> Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p><b>Findings:</b> In collaboration with LAC-USC, MSH updated the practice guideline for managing individuals who swallow foreign objects. The updated guideline will be implemented and monitored effective March 2011.</p> <p><b>Recommendation 4, September 2010:</b> Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</p>	1.	<i>Admission/Annual Physical Assessments: (Timeliness, Completeness and Quality)</i>	99%	2.	<i>Quarterly Notes; (Timeliness, Completeness and Quality)</i>	96%	3.	<i>Progress/Transfer/Acceptance Notes: (Timeliness, Completeness and Quality)</i>	100%
1.	<i>Admission/Annual Physical Assessments: (Timeliness, Completeness and Quality)</i>	99%									
2.	<i>Quarterly Notes; (Timeliness, Completeness and Quality)</i>	96%									
3.	<i>Progress/Transfer/Acceptance Notes: (Timeliness, Completeness and Quality)</i>	100%									

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		<p><b>Findings:</b>  <b>MSH</b> presented process and clinical outcome data based on the following indicators. In general, the data demonstrated that the facility has maintained positive outcomes.</p> <ol style="list-style-type: none"> <li>1. Process outcomes tracked:             <ol style="list-style-type: none"> <li>a. Number of individuals newly diagnosed with diabetes mellitus;</li> <li>b. Number of individuals newly diagnoses with diabetes mellitus and receiving new generation antipsychotics;</li> <li>c. Percentage of individuals whose BMI is tracked monthly;</li> <li>d. Inclusion of WRP objectives and interventions for constipation;</li> <li>e. Number of individuals with 3+ falls in 30 days;</li> <li>f. Total number of falls;</li> <li>g. Timeliness and appropriateness of external consultations;</li> <li>h. Review process for unexpected deaths; and</li> <li>i. Number of individuals receiving Clozaril.</li> </ol> </li>   <li>2. Clinical outcomes tracked:             <ol style="list-style-type: none"> <li>a. Average HA1c levels for all individuals with diabetes mellitus;</li> <li>b. HA1c readings for all individuals with diabetes mellitus who also receive new generation antipsychotics;</li> <li>c. Number of individuals with dyslipidemia with LDL &lt;130;</li> <li>d. Percentage of individuals with dyslipidemia with LDL &lt;100;</li> <li>e. Average body mass index of individuals with BMI &gt;25;</li> <li>f. Percentage of individuals diagnosed with hypertension with blood pressure &lt;140/90;</li> <li>g. Percentage of individuals with diabetes mellitus with blood pressure &lt;130/80;</li> <li>h. Number of individuals hospitalized for bowel dysfunction;</li> <li>i. Individuals with falls resulting in major injury;</li> <li>j. Number of individuals diagnosed with aspiration pneumonia;</li> <li>k. Number of individuals with refractory seizures;</li> </ol> </li> </ol>
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		<ul style="list-style-type: none"><li>l. Number of individuals with status epilepticus;</li><li>m. Timeliness and appropriateness of external consultations; and</li><li>n. Number of unexpected mortalities</li></ul> <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ul style="list-style-type: none"><li>1. Provide summary regarding status of implementation of the reprivileging process, including specific information about the performance indicators and number and percentage of providers who were reassessed using these indicators.</li><li>2. Provide peer review data analysis, based on the medical chart audit, regarding practitioner and group trends, with corrective actions as indicated.</li><li>3. Continue to update practice guidelines guided by current literature and relevant clinical experience.</li><li>4. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</li></ul>
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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Liezl De Guzman, RN, HSS</li> <li>2. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>3. Loraine Clinton, PHN</li> <li>4. Michael Nunley, RN, Acting Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH IC Admission PPD summary data, August 2010 - January 2011</li> <li>2. MSH IC Annual PPD Audit summary data, August 2010 - January 2011</li> <li>3. MSH IC Hepatitis C Audit summary data, August 2010 - January 2011</li> <li>4. MSH IC HIV Positive Audit summary data, August 2010 - January 2011</li> <li>5. MSH IC Immunization Audit summary data, August 2010 - January 2011</li> <li>6. MSH IC Immunization Refusal Audit summary data, August 2010 - January 2011</li> <li>7. MSH IC MRSA Audit summary data, August 2010 - January 2011</li> <li>8. MSH IC Positive PPD Audit summary data, August 2010 - January 2011</li> <li>9. MSH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit summary data, August 2010 - January 2011</li> <li>10. MSH IC Sexually Transmitted Disease (STD) Audit summary data, August 2010 - January 2011</li> <li>11. Quarterly Infection control Committee Meeting minutes, dated 8/25/10, 10/27/10 and 12/22/10</li> <li>12. Medical Executive Committee Meeting minutes dated 8/2/10, 9/13/10, 10/25/10, 11/15/10 and 12/6/10</li> <li>13. Medical records for the following 55 individuals: AH, AMA, ANH, BB, BHW, BJW, CAH, CCT, CG, CRB, DEK, DEM, DH, DIM, DK, GA, GAR, HID, HOP, JAS, JDC, JDJ, JLR, JWP, JWS, LIJ, MEC, MH, MKC,</li> </ol>

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		MLC, MM, MTA, MW, NM, OAM, PBJ, PLB, RG, RLV, RLW, RRR, SAT, SDK, SE, SGC, SLL, SRS, STL, TCH, TOM, TRD, VIC, VRB, WAM and WIP															
F.8.a	Each State hospital shall establish an effective infection control program that:	<b>Compliance:</b> Partial.															
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings (by test/disease):</b></p> <p><b><u>Admission PPD</u></b> Using the DMH IC Admission PPD Audit, MSH assessed its compliance based on an average sample of 23% of individuals admitted to the hospital with a negative PPD in the review months (August 2010 - January 2011):</p> <table border="1"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>85%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1-4. The</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%	4.	<i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%	5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	85%
1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%															
2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%															
3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	100%															
4.	<i>1<sup>st</sup> step PPDs were read by the nurse within 7 days of administration.</i>	100%															
5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	85%															

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		<p>compliance rate for item 5 was 100% in the previous period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> Item 5 was below 90% compliance during the month of September 2010.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> All admission records were reviewed and the TSTs were completed.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> All TST were entered into the public health database.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of 18 individuals admitted during the review period (AH, ANH, BJW, CAH, DEM, GA, JAS, JDJ, JWP, MH, MLC, PLB, RG, RLV, RLW, SDK, TOM and VRB) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><b><u>Annual PPD</u></b> Using the DMH IC Annual PPD Audit, MSH assessed its compliance based on an average sample of 35% of individuals needing an annual PPD during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1079 1890 1383"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td>100%</td> </tr> </table>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	100%												
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%												

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> None required.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement</p> <p>A review of the records of 15 individuals requiring an annual PPD during the review period (AMA, CCT, DEK, HID, HOP, MW, OAM, PBJ, RRR, SGC, SLL, TCH, TRD, VIC and WIP) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><b><u>Hepatitis C</u></b> Using the DMH IC Hepatitis C Audit, MSH assessed its compliance based on an average sample of 33% of individuals admitted to the hospital in the review months (August 2010 - January 2011) who were positive for Hepatitis C:</p> <table border="1" data-bbox="991 1154 1890 1414"> <tr> <td data-bbox="991 1154 1087 1263">1.</td> <td data-bbox="1087 1154 1793 1263"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 1154 1890 1263">100%</td> </tr> <tr> <td data-bbox="991 1263 1087 1372">2.</td> <td data-bbox="1087 1263 1793 1372"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1263 1890 1372">83%</td> </tr> <tr> <td data-bbox="991 1372 1087 1414">3.</td> <td data-bbox="1087 1372 1793 1414"><i>Hepatitis C Tracking sheet was initiated on the Public</i></td> <td data-bbox="1793 1372 1890 1414">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	83%	3.	<i>Hepatitis C Tracking sheet was initiated on the Public</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%									
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	83%									
3.	<i>Hepatitis C Tracking sheet was initiated on the Public</i>	100%									

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		<table border="1"> <tr> <td data-bbox="989 191 1087 266"></td> <td data-bbox="1087 191 1793 266"><i>Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 191 1896 266"></td> </tr> <tr> <td data-bbox="989 266 1087 341">4.</td> <td data-bbox="1087 266 1793 341"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 266 1896 341">67%</td> </tr> <tr> <td data-bbox="989 341 1087 380">5.</td> <td data-bbox="1087 341 1793 380"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 341 1896 380">100%</td> </tr> <tr> <td data-bbox="989 380 1087 454">6.</td> <td data-bbox="1087 380 1793 454"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 380 1896 454">100%</td> </tr> <tr> <td data-bbox="989 454 1087 570">7.</td> <td data-bbox="1087 454 1793 570"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1793 454 1896 570">100%</td> </tr> </table>		<i>Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>		4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	67%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%	
	<i>Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>																	
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	67%																
5.	<i>A Focus 6 is opened for Hepatitis C.</i>	100%																
6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	100%																
7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	100%																
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 3, and 5-7. The compliance rates for items 2 and 4 were 100% and 82% respectively in the previous period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u>          In December, compliance for item 2 was 83%. The IDNs did not reflect the individual was admitted with Hepatitis C although objectives and interventions were written in the WRPs. In December and January, compliance for item 4 was 0%. The medication review sheets were not found in THE record at THE time of audits; however, the immunizations were ordered.</p> <p>.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u>          See below.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u>          MSH's PHNs redistributed the medication review form to the medical consultants for each Program and emailed reminders to complete the medication review form to medical consultants of the admissions units. The Chief Physician &amp; Surgeon of Medical Services was given results of the audits as well the Infection Control Committee.</p>																

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement. Nursing administration will continue to provide the audit results to the Chief Physician &amp; Surgeon of Medical Services.</p> <p>A review of the records of five individuals who were admitted Hepatitis C positive during the review period (DH, GAR, MEC, MTA and STL) found that all contained documentation that the medication plan and immunizations were evaluated; all had an open Focus 6 for Hepatitis C; and all had adequate and appropriate objectives and interventions.</p> <p><b><u>HIV Positive</u></b> Using the DMH IC HIV Positive Audit, MSH assessed its compliance based on a 88% sample (four individuals out of five) of individuals who were positive for HIV antibody in the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 857 1890 1416"> <tr> <td data-bbox="991 857 1087 971">1.</td> <td data-bbox="1087 857 1795 971"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1795 857 1890 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1084">2.</td> <td data-bbox="1087 971 1795 1084"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1795 971 1890 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1087 1198">3.</td> <td data-bbox="1087 1084 1795 1198"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1795 1084 1890 1198">100%</td> </tr> <tr> <td data-bbox="991 1198 1087 1312">4.</td> <td data-bbox="1087 1198 1795 1312"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1795 1198 1890 1312">N/A</td> </tr> <tr> <td data-bbox="991 1312 1087 1416">5.</td> <td data-bbox="1087 1312 1795 1416"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless</i></td> <td data-bbox="1795 1312 1890 1416">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless</i>	100%
1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%															
2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%															
3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%															
4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A															
5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless</i>	100%															

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			<i>another timeframe is ordered by the physician.</i>	
		6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%
		7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%
		8.	<i>Appropriate interventions are written.</i>	100%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of four individuals who were admitted during the review period with HIV (CG, JDC, JDJ and NM) found that all were in compliance regarding clinic referrals and follow-up, and all WRPs contained appropriate objectives and/or interventions.</p> <p><b><u>Immunizations</u></b> Using the DMH IC Immunization Audit, MSH assessed its compliance based on an average sample of 23% of individuals admitted to the hospital during the review months (August 2010 - January 2011):</p>		
		1.	<i>Notification by the lab was made to the Infection</i>	100%

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		<table border="1"> <tr> <td data-bbox="989 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 190 1890 228"></td> </tr> <tr> <td data-bbox="989 228 1087 305">2.</td> <td data-bbox="1087 228 1793 305"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 228 1890 305">100%</td> </tr> <tr> <td data-bbox="989 305 1087 381">3.</td> <td data-bbox="1087 305 1793 381"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 305 1890 381">95%</td> </tr> <tr> <td data-bbox="989 381 1087 493">4.</td> <td data-bbox="1087 381 1793 493"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 381 1890 493">100%</td> </tr> </table>		<i>Control Department of an individual's immunity status.</i>		2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	95%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%	<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 2 and 4; the compliance rate for item 3 was 89% in the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement</p> <p>A review of the records of 18 individuals (AH, ANH, BJW, CAH, DEM, GA, JAS, JDJ, JWP, MH, MLC, PLB, RG, RLV, RLW, SDK, TOM and VRB) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><b><u>Immunization Refusals</u></b> Using the DMH IC Immunization Refusal Audit, MSH assessed its</p>
	<i>Control Department of an individual's immunity status.</i>														
2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%													
3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	95%													
4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%													

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		<p>compliance based on a 29% sample (43 individuals) of individuals in the hospital who refused to take their immunizations during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 337 1890 824"> <tr> <td data-bbox="991 337 1087 451">1.</td> <td data-bbox="1087 337 1795 451"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1795 337 1890 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 526">2.</td> <td data-bbox="1087 451 1795 526"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1795 451 1890 526">0%</td> </tr> <tr> <td data-bbox="991 526 1087 600">3.</td> <td data-bbox="1087 526 1795 600"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 526 1890 600">0%</td> </tr> <tr> <td data-bbox="991 600 1087 711">4.</td> <td data-bbox="1087 600 1795 711"><i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1795 600 1890 711">0%</td> </tr> <tr> <td data-bbox="991 711 1087 824">5.</td> <td data-bbox="1087 711 1795 824"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1795 711 1890 824">0%</td> </tr> </table> <p>Data for this and the previous review were found to be unreliable.</p> <p>Although MSH provided data for Immunization Refusals and reported that "there were no problematic trends and individuals who may have refused initially did not refuse on second or third request/offer," it was evident from discussions on site that the facility did not have a tracking system in place to be able to identify individuals who had refused their immunizations three times. Consequently, the data initially provided was not accurate and MSH could not produce a list of individuals who had refused their immunizations three times, which would require WRPT intervention. Thus, no review of this requirement could be conducted by the reviewer. The revised data for this section provided by the facility after the review could not be interpreted and basically did not make any sense.</p>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	0%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	0%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	0%	5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	0%
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%															
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	0%															
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	0%															
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).</i>	0%															
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	0%															

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		<p><u>F.8.a.ii: Assesses these data for trends</u> See above.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> See above.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> See above.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> See above.</p> <p>Due to the lack of a tracking system, it was not possible to review records of individuals who refused immunizations during the review period.</p> <p><b><u>MRSA</u></b> Using the DMH IC MRSA Audit, MSH assessed its compliance based on a 100% sample (three individuals) of individuals in the hospital who tested positive for MRSA during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1003 1887 1414"> <tr> <td data-bbox="991 1003 1087 1117">1.</td> <td data-bbox="1087 1003 1793 1117"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 1003 1887 1117">100%</td> </tr> <tr> <td data-bbox="991 1117 1087 1230">2.</td> <td data-bbox="1087 1117 1793 1230"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 1117 1887 1230">67%</td> </tr> <tr> <td data-bbox="991 1230 1087 1305">3.</td> <td data-bbox="1087 1230 1793 1305"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 1230 1887 1305">0%</td> </tr> <tr> <td data-bbox="991 1305 1087 1380">4.</td> <td data-bbox="1087 1305 1793 1380"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 1305 1887 1380">100%</td> </tr> <tr> <td data-bbox="991 1380 1087 1414">5.</td> <td data-bbox="1087 1380 1793 1414"><i>The public health office contacts the unit RN and</i></td> <td data-bbox="1793 1380 1887 1414">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	67%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	0%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%															
2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	67%															
3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	0%															
4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%															
5.	<i>The public health office contacts the unit RN and</i>	100%															

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		<table border="1"> <tr> <td></td> <td><i>provides MRSA protocol and guidance for the care of the individual.</i></td> <td></td> </tr> <tr> <td>6.</td> <td><i>A Focus 6 is opened for MRSA.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate interventions are written to include contact precautions.</i></td> <td>100%</td> </tr> </table>		<i>provides MRSA protocol and guidance for the care of the individual.</i>		6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
	<i>provides MRSA protocol and guidance for the care of the individual.</i>													
6.	<i>A Focus 6 is opened for MRSA.</i>	100%												
7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%												
8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%												
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% for items 1 and 4-8. The compliance rates for items 2 and 3 were 90% and 100% respectively in the previous review period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> Items 2 and 3 demonstrated a significant decrease in compliance.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Documentation for items 2 and 3 was not found in the Interdisciplinary Notes.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> The Infection Control Liaison and PHNs provided mentoring and training.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of three individuals with MRSA (BB, MM and RG) found that all individuals were ordered "MRSA Precautions" rather than "Contact Precautions," which is the appropriate term; all individuals were placed on the appropriate antibiotic; and all WRPs contained appropriate objectives and interventions.</p> <p><b><u>Positive PPD</u></b> Using the DMH IC Positive PPD Audit, MSH assessed its compliance</p>												

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		<p>based on an average sample of 86% of individuals in the hospital who had a positive PPD test during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 337 1885 906"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>92%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>58%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td>83%</td> </tr> <tr> <td>7.</td> <td><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td>75%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 2, and 5. Compliance rates for items 3, 6 and 7 were all 100% in the previous review period. (Item 4 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u>          The compliance rate for item 3 fell below 90% in September, October, December, and January due to incomplete physicians' notes regarding positive TSTs.          The compliance rates for items 6 and 7 fell below 90% in November due to objectives and interventions not written to standard.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u></p>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	92%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	58%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	83%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	75%
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		<p>See below.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> The IC Committee has approved going back to having a designated physician see all individuals with a positive TST in the clinic for consistency. In addition, the IC Liaison provided mentoring to unit staff.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of seven individuals who had a positive PPD (BHW, CRB, DK, JLR, SE, SRS and WAM) found that all individuals had the required chest x-rays; three records contained documentation of an evaluation from the physician; and all WRPs contained appropriate objectives and interventions.</p> <p><b><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u></b> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, MSH assessed its compliance based on a 100% sample of individuals (ten individuals) in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1040 1892 1416"> <tr> <td data-bbox="991 1040 1087 1192">1.</td> <td data-bbox="1087 1040 1793 1192"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i></td> <td data-bbox="1793 1040 1892 1192">100%</td> </tr> <tr> <td data-bbox="991 1192 1087 1268">2.</td> <td data-bbox="1087 1192 1793 1268"><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td data-bbox="1793 1192 1892 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1344">3.</td> <td data-bbox="1087 1268 1793 1344"><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1268 1892 1344">100%</td> </tr> <tr> <td data-bbox="991 1344 1087 1416">4.</td> <td data-bbox="1087 1344 1793 1416"><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td data-bbox="1793 1344 1892 1416">100%</td> </tr> </table>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%	2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	100%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	100%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%
1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.</i>	100%												
2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	100%												
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4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	100%												

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		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>A review of the records of five individuals who refused admitting or annual labs/diagnostics (DIM, JWS, LIJ, MKC and SAT) found that all refusals were adequately addressed in the WRPs.</p> <p><b><u>Sexually Transmitted Diseases</u></b> Using the DMH IC Sexually Transmitted Disease (STD) Audit, MSH assessed its compliance based on an average sample of 100% of individuals (one individual) in the hospital who tested positive for an STD during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1149 1887 1412"> <tr> <td data-bbox="991 1149 1087 1224">1.</td> <td data-bbox="1087 1149 1793 1224"><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td data-bbox="1793 1149 1887 1224">100%</td> </tr> <tr> <td data-bbox="991 1224 1087 1299">2.</td> <td data-bbox="1087 1224 1793 1299"><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td data-bbox="1793 1224 1887 1299">100%</td> </tr> <tr> <td data-bbox="991 1299 1087 1373">3.</td> <td data-bbox="1087 1299 1793 1373"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1793 1299 1887 1373">100%</td> </tr> <tr> <td data-bbox="991 1373 1087 1412">4.</td> <td data-bbox="1087 1373 1793 1412"><i>An HIV antibody test is offered to every individual</i></td> <td data-bbox="1793 1373 1887 1412">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%												
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%												
3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%												
4.	<i>An HIV antibody test is offered to every individual</i>	100%												

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			<i>upon admission.</i>	
		5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	N/A
		6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A
		7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%
		8.	<i>Appropriate objective(s) are written.</i>	100%
		9.	<i>Appropriate interventions are written.</i>	100%
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 5 was N/A in the previous period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p> <p>The individual with a diagnosed STDs was discharged and the medical record was not available for review.</p> <p><b>Compliance:</b> Partial.</p>		

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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that data accurately reflects facility practices.</li> <li>2. Implement a system addressing and tracking refusals for immunizations.</li> <li>3. Implement strategies addressing areas of low compliance.</li> <li>4. Continue to monitor this requirement.</li> </ol>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's key indicator data from the facility accurately reflected the infection control trends for the review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p>

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		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.iv	identifies necessary corrective action;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	<p><b>Current findings on previous recommendation:</b></p>

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		<p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Review of the minutes of MSH's meetings verified that IC data are discussed at the Infection Control Committee meetings and other discipline committee meetings and are included in the Facility's key indicator data.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Ashvind Singh, PhD, Psychologist, Treatment Enhancement Coordinator</li> <li>2. Sheri Greve, PsyD, Acting Chief of Psychology</li> <li>3. Toni Nguyen, DDS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Dental Services Audit summary data, August 2010 - January 2011</li> <li>2. MSH's progress report</li> <li>3. MSH's Refusal and risk list</li> <li>4. Medical records for the following 93 individuals: AA, AAM, ACR, AF, AFF, AJS, AM, AMA, AR, BCC, BJL, BKW, BLW, BMW, BRS, CAL, CCL, CCT, CDL, CLG, CTC, DEK, DF, DIH, DM, DRI, DRR, DRT, DW, EFL, FGS, FNK, FOR, GSS, HEL, HH, HID, HOP, JA, JDH, JED, JER, JJR, JLS, JN, JQM, JS, JTS, KS, LA, LEP, LHS, LJ, LVT, MAO, MGS, MKC, MLM, MM, MMR, MW, MWV, OAM, OH, OOH, PBJ, PRP, RA, RAD, RAR, RBP, RDJ, RR, RRC, RRR, SDS, SGC, SLF, SLL, SMC, SML, SO, SP, TCC, TCH, THR, TRD, VC, VIC, VV, VVZ, WIP and WM</li> </ol>
<p>F.9.a</p>	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, one dental assistant retired in December 2010 and a new assistant was hired and started in February 2011. In the interim, an annuitant assistant came in to assist the Dental Department to prevent any disruption to the Dental Clinic's activities.</p>

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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p><b>Compliance:</b> Substantial.</p>			
F.9.b.i	comprehensive and timely provision of dental services;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for comprehensive dental exams during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 896 1892 935"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 23 individuals (AA, AJS, BCC, BLW, DIH, EFL, HEL, HH, JJR, JN, KS, LEP, LHS, LVT, MMR, RA, RAR, RBP, SMC, SML, SO, TCC and VV) found that all individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals who have been in the hospital for 90 days or less during the review period (August 2010 - January 2011):</p>	1.a	<i>Comprehensive dental exam was completed</i>	98%
1.a	<i>Comprehensive dental exam was completed</i>	98%			

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		<table border="1"> <tr> <td data-bbox="976 181 1081 235">1.b</td> <td data-bbox="1081 181 1795 235"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1795 181 1921 235">98%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</i>	98%
1.b	<i>If admission examination date was 90 days or less</i>	98%			
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 23 individuals (AA, AJS, BCC, BLW, DIH, EFL, HEL, HH, JJR, JN, KS, LEP, LHS, LVT, MMR, RA, RAR, RBP, SMC, SML, SO, TCC and VV) found that all individuals were timely seen for their admission exams.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (August 2010 - January 2011):</p>					
<table border="1"> <tr> <td data-bbox="976 706 1081 787">1.c</td> <td data-bbox="1081 706 1795 787"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1795 706 1921 787">99%</td> </tr> </table>			1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%
1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%			
<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals (AMA, CCT, DEK, HID, HOP, MW, OAM, PBJ, RRR, SGC, SLL, TCH, TRD, VIC and WIP) found that all annual exams were timely completed.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (August 2010 - January 2011):</p>					
<table border="1"> <tr> <td data-bbox="976 1258 1081 1421">1.d</td> <td data-bbox="1081 1258 1795 1421"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1795 1258 1921 1421">97%</td> </tr> </table>			1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	97%
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	97%			

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		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 38 individuals (AA, AJS, AMA, BCC, BLW, CCT, DEK, DIH, EFL, HEL, HH, HID, HOP, JJR, JN, KS, LEP, LHS, LVT, MMR, MW, OAM, PBJ, RA, RAR, RBP, RRR, SGC, SLL, SMC, SML, SO, TCC, TCH, TRD, VIC, VV and WIP) found that all individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals with dental problems identified other than on admission or annual examination during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 711 1890 860"> <tr> <td data-bbox="991 711 1087 860">1.e</td> <td data-bbox="1087 711 1795 860"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1795 711 1890 860">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 13 individuals (AAM, AR, CDL, CTC, DW, FOR, JQM, LJ, MKC, MM, PRP, VC and WM) found that all individuals received timely follow-up care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	97%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	97%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p>			

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		<p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 10% sample of individuals scheduled for follow-up dental care during the review months (August 2010 - January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of dental documentation for 38 individuals (AA, AJS, AMA, BCC, BLW, CCT, DEK, DIH, EFL, HEL, HH, HID, HOP, JJR, JN, KS, LEP, LHS, LVT, MMR, MW, OAM, PBJ, RA, RAR, RBP, RRR, SGC, SLL, SMC, SML, SO, TCC, TCH, TRD, VIC, VV and WIP) found compliance with the documentation requirements in all 38 cases.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals due for annual routine dental examinations during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 1227 1892 1341"> <tr> <td data-bbox="991 1227 1087 1341">3.a</td> <td data-bbox="1087 1227 1793 1341"><i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 1227 1892 1341">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	99%
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Section F: Specific Therapeutic and Rehabilitation Services

		<p>least 90% from the previous review period.</p> <p>A review of the records of 14 individuals (ACR, AF, AM, BKW, CAL, DRI, DRR, DRT, JS, MAO, OH, RAD, SLF and VVZ) found that all 14 individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="991 561 1892 638"> <tr> <td data-bbox="991 561 1087 638">3.c</td> <td data-bbox="1087 561 1795 638"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1795 561 1892 638">97%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 12 individuals (BMW, BRS, CCL, FGS, JDH, JER, JLS, MGS, RR, SDS, TCC and THR) found that all 12 individuals received restorative care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	97%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	97%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals who had tooth extractions during the review months (August 2010 - January 2011):</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>4. <i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></p>	<p>100%</p>
<p>F.9.c Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>		<p><b>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</b></p> <p>A review of the records of 13 individuals (AAM, AR, CDL, CTC, DW, FOR, JQM, LJ, MKC, MM, PRP, VC and WM) found that all records were in compliance with this requirement.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p> <hr/> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 10% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (August 2010 - January 2011) and reported a mean compliance rate of 100%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 38 individuals (AA, AJS, AMA, BCC, BLW, CCT, DEK, DIH, EFL, HEL, HH, HID, HOP, JJR, JN, KS, LEP, LHS, LVT,</p>	

Section F: Specific Therapeutic and Rehabilitation Services

		<p>MMR, MW, OAM, PBJ, RA, RAR, RBP, RRR, SGC, SLL, SMC, SML, SO, TCC, TCH, TRD, VIC, VV and WIP) found that all 38 records were in compliance with the documentation requirements.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																							
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% sample of individuals scheduled for dental appointments during the review months (August 2010 - January 2011):</p> <table border="1" data-bbox="993 933 1892 971"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>53%</td> </tr> </table> <p>Comparative data indicated a decrease in compliance from 56% in the previous review period.</p> <p>The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 1193 1818 1417"> <thead> <tr> <th>Month</th> <th>Refused to come to appt</th> <th>Unit staff procedural problem</th> <th>Transportation problem</th> </tr> </thead> <tbody> <tr> <td>Aug 10</td> <td>83</td> <td>0</td> <td>0</td> </tr> <tr> <td>Sep 10</td> <td>88</td> <td>0</td> <td>0</td> </tr> <tr> <td>Oct 10</td> <td>82</td> <td>0</td> <td>0</td> </tr> <tr> <td>Nov 10</td> <td>86</td> <td>0</td> <td>0</td> </tr> </tbody> </table>	6.a	<i>The individual attended the scheduled appointment</i>	53%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	Aug 10	83	0	0	Sep 10	88	0	0	Oct 10	82	0	0	Nov 10	86	0	0
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Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="997 191 1818 269"> <tr> <td>Dec 10</td> <td>87</td> <td>1</td> <td>1</td> </tr> <tr> <td>Jan 11</td> <td>85</td> <td>1</td> <td>1</td> </tr> </table> <p>A review of MSH's dental logs confirmed that staffing and transportation were not the major issues precluding individuals from attending dental appointments. The Chief Dentist also noted that conflicting schedules with the Mall and grounds pass activities have also contributed to missed dental appointments since some of the individuals prefer to attend Mall activities over attending their dental appointments.</p> <p>See F.9.e for findings regarding dental refusals.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	Dec 10	87	1	1	Jan 11	85	1	1
Dec 10	87	1	1							
Jan 11	85	1	1							
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, September 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues.</li> <li>• Continue strategies to ensure that WRPs addressing refusals are individualized.</li> </ul> <p><b>Findings:</b> MSH did not address these recommendations.</p> <p><b>Recommendation 3, September 2010:</b> Continue to monitor this requirement.</p>								

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b>          Using the DMH Dental Services Audit, MSH assessed its compliance based on a 28% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (August 2010 - January 2011) and reported a mean compliance rate of 96%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals (AFF, BJL, CLG, DF, DM, FNK, GSS, JA, JED, JTS, LA, MLM, MWV, OOH, RDJ, RRC and SP) found that three (RDJ, RRC, and SP) contained an open focus for refusals but had no mention of dental appointments being refused. In addition, these WRPs were basically generic and not adequate for individuals who were deemed high risk related to their dental refusals. There was no open focus for the remaining 14 individuals although the refusals and referrals to the WRPTs were clearly documented in the dental notes. These findings do not comport with MSH's data. From discussions with the Acting Chief of Psychology and Enhancement Coordinator, MSH's system addressing and tracking refusals had not been fully implemented at the time of the review.</p> <p><b>Compliance:</b>          Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues.</li> <li>2. Ensure that WRPs addressing refusals are individualized.</li> <li>3. Continue to monitor this requirement.</li> </ol>
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Section G: Documentation

G. Documentation		
G	<p>Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.</p>	<p><b>Summary of Progress:</b> Please refer to Sections D, E, F and H for judgments on the progress MSH has made towards aligning documentation practices with the requirements of the EP.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. MSH continues to be committed to decreasing the use the restraint and seclusion and has maintained substantial compliance with most of the areas of Section H.</li> <li>2. The Facility needs to aggressively review the use of side rails, especially for the Skilled Nursing units, to ensure that safe practices are being used and review its practices for identifying and reviewing Sentinel Events.</li> </ol>
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Carmen Fayloga, HSS Standards Compliance</li> <li>2. Michael Nunley, RN, Nurse Administrator</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH Seclusion/Restraint Audit summary data, August 2010 - January 2011</li> <li>2. Medical records for the following individuals: DEK, ED, FC, FCR, HEL, HHT, JJS, JKW, JR, LJO, LK, MCF, NK and VMC</li> <li>3. MSH's progress report</li> <li>4. MSH training rosters</li> <li>5. MSH's new debriefing form: MSH 1259 - Seclusion/Restraint Debriefing Form</li> <li>6. Medical Risk Management Committee minutes dated 2/23/2011</li> <li>7. Immediate Action Plan, Recommendation Sheet, and WRP for individual JRL</li> </ol> <p><u>Observed:</u></p> <p>Individual JRL on unit 419</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

<p>H.1</p>	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, there have been no revisions made to Special Order 119.06 (Seclusion and Behavioral Restraint) or AD 3306 (Behavioral Seclusion or Restraint). There were no incidents of prone restraint, prone containment or prone transportation found during the current review. In addition, MSH will be implementing a newly approved debriefing form (MSH 1259 - Seclusion/Restraint Debriefing Form), which integrates input and feedback from both individual and staff involved in any restraint or seclusion event. This will assist in identifying and addressing potential adverse effects and possible trauma from the restrictive event, and potentially reducing future episodes.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice..</p>
<p>H.2</p>	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p><b>Compliance:</b> Substantial.</p>
<p>H.2.a</p>	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>based on a 100% sample of initial seclusion orders (a total of 11 episodes) during the review period (August 2010 - January 2011):</p> <table border="1"> <tr> <td data-bbox="993 305 1087 342">1.</td> <td data-bbox="1087 305 1793 342"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1793 305 1890 342">100%</td> </tr> <tr> <td data-bbox="993 342 1087 418">2.</td> <td data-bbox="1087 342 1793 418"><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 342 1890 418">100%</td> </tr> <tr> <td data-bbox="993 418 1087 532">3.</td> <td data-bbox="1087 418 1793 532"><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 418 1890 532">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of six episodes of seclusion for six individuals (HEL, HHT, JJS, LJO, LK and VMC) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial restraint orders (a total of 71 episodes) during the review period (August 2010 - January 2011):</p> <table border="1"> <tr> <td data-bbox="993 1049 1087 1086">1.</td> <td data-bbox="1087 1049 1793 1086"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 1049 1890 1086">100%</td> </tr> <tr> <td data-bbox="993 1086 1087 1162">2.</td> <td data-bbox="1087 1086 1793 1162"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 1086 1890 1162">100%</td> </tr> <tr> <td data-bbox="993 1162 1087 1276">3.</td> <td data-bbox="1087 1162 1793 1276"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 1162 1890 1276">99%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Seclusion is used in a documented manner.</i>	100%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%	1.	<i>Restraint is used in a documented manner.</i>	100%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%
1.	<i>Seclusion is used in a documented manner.</i>	100%																		
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%																		
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>A review of 20 episodes of restraint for eight individuals (DEK, ED, FC, FCR, JKW, JR, MCF and NK) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>									
H.2.b	<p>are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (August 2010 - January 2011):</p> <table border="1" data-bbox="991 933 1890 1416"> <tr> <td data-bbox="991 933 1087 1008">4.</td> <td data-bbox="1087 933 1795 1008"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1795 933 1890 1008">91%</td> </tr> <tr> <td data-bbox="991 1008 1087 1230">5.</td> <td data-bbox="1087 1008 1795 1230"><i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i></td> <td data-bbox="1795 1008 1890 1230">100%</td> </tr> <tr> <td data-bbox="991 1230 1087 1416">6.</td> <td data-bbox="1087 1230 1795 1416"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical</i></td> <td data-bbox="1795 1230 1890 1416">100%</td> </tr> </table>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	91%	5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 85%;"><i>justification as to why they were not used.</i></td> <td style="width: 10%;"></td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of six episodes of seclusion for six individuals (HEL, HHT, JJS, LJO, LK and VMC) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (August 2010 - January 2011):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">4.</td> <td style="width: 85%;"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td style="width: 10%;">99%</td> </tr> <tr> <td>5.</td> <td><i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of 20 episodes of restraint for eight individuals (DEK, ED, FC,</p>		<i>justification as to why they were not used.</i>		4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	99%	5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>	100%	6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
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Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>FCR, JKW, JR, MCF and NK) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.2.c	are not used as part of a behavioral intervention; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.2.c.iv.</p> <p><b>Findings:</b> See F.2.c.iv.</p> <p><b>Current recommendations:</b> See F.2.c.iv.</p>
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of episodes of seclusion each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p>

Section H: Restraints, Seclusion, and PRN and Stat Medication

		<p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% sample of episodes of restraint each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 99%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance with the one-hour requirement based on a 100% sample of initial seclusion orders each month during the review period (August 2010 - January 2011) and reported a mean compliance rate of 97%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of six episodes of seclusion for six individuals (HEL, HHT, JJS, LJO, LK and VMC) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH also assessed its compliance with the one-hour requirement based on a 100% mean sample of initial restraint orders each month during the review period (August</p>

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		<p>2010 - January 2011) and reported a mean compliance rate of 91%. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 20 episodes of restraint for eight individuals (DEK, ED, FC, FCR, JKW, JR, MCF and NK) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in 19 episodes.</p> <p>MSH's training rosters indicated that all existing staff and newly hired that was required to attend the Annual TSI (Therapeutic Strategies and Interventions) Training attended and passed.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Standards Compliance continues to check the Seclusion/Restraint WaRMSS database at least monthly and coordinates with the Programs and the IT Department to reconcile identified discrepancies in these data. The HSS Daily 24-Hour Report on Seclusion/Restraint Use is also utilized to reconcile Seclusion/Restraint data. MSH reported that the accuracy of Seclusion/Restraint use entered in the Seclusion/Restraint WaRMSS database for this review period was 100%.</p>

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		<p>In addition, Standards Compliance continues to review the PRN/Stat WaRMSS database to ensure that the units have consistently and accurately entered this information into the database. The Plato Data Analyzer for data entry and reporting is also used in establishing data accuracy. A review of PRN/Stat medications and seclusion and restraint incidents found no instances that were not included in MSH's databases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> There were no incidents of individuals placed in seclusion more than three times in 30 days during the review period (August 2010 - January 2011).</p> <p>Using the DMH Seclusion/Restraint Audit, MSH also assessed its compliance based on a 100% sample of individuals who were in restraint more than three times in 30 days during the review period (August 2010 - January 2011) and reported a mean compliance rate of 100% with the three-day review requirement. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of three individuals who were in restraint more than three times in 30 days during the review period (ED, DC and NK) found that all three WRPs included documentation within three business</p>

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		<p>days.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p><b>Compliance:</b> Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p>

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		<p><b>Current recommendation:</b> See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.1.b.</p> <p><b>Findings:</b> See F.1.b.</p> <p><b>Current recommendation:</b> See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.3.a.iii.</p> <p><b>Findings:</b> See F.3.a.iii.</p> <p><b>Current recommendations:</b> See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> Same as in D.1.f, F.1.b and H.6.a.</p> <p><b>Findings:</b> Same as in D.1.f, F.1.b and H.6.a</p>

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		<p><b>Current recommendations:</b> Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	<p>Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010:</b> See F.3.h.i and H.3.</p> <p><b>Findings:</b> See F.3.h.i and H.3.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
H.8	<p>Each State hospital shall:</p>	<p><b>Compliance:</b> Noncompliance.</p>
H.8.a	<p>develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and</p>	<p>See H.8.b.</p>
H.8.b	<p>ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, January 2010:</b> See H.8.a.</p> <p><b>Findings:</b> The WRP dated 2/15/2011 of individual JRL indicated that on 2/17/2011, "he was found hanging on the side of his bed in between his upper and lower side rails with roll belt still intact." He was found to be</p>

		<p>"unresponsive, pale and cold with moist skin, apneic" and was given oxygen and taken by paramedics to the community hospital. The recommendations contained in the minutes of the Medical Risk Management Committee (MRMC) dated 2/23/2011 were clinically inappropriate and did not adequately or aggressively address this critical event. Discussions with the facility revealed that although the recommendations from the MRMC were inadequate, there was no documentation indicating that any of the interventions addressing the individual's safety were actually implemented. On 2/28/2011, a second incident occurred in which the individual was found on the floor by the side of his bed. A second set of recommendations was generated on 3/4/2011, but most were clinically inadequate and had not been implemented at the time of this review. In fact, some of these recommendations were the same as noted from the MRMC minutes. At the time of the review, there had been no appropriate interventions implemented to ensure that the individual was safe and that the serious risks of the use of side rails had been adequately addressed. In addition, the facility had not identified these events as Sentinel Events, which warrant a critical and intense review of the incidents including timely implementation of clinically appropriate interventions and trigger a thorough review of the facility's practices related to these events.</p> <p>During the review, the facility developed an Immediate Action Plan that included obtaining consultation from a local Developmental Center to assist in assessing the individual's positioning needs as well as increased assessments and monitoring while these assessments are being obtained.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. The facility needs to aggressively review the use of side rails, especially for the Skilled Nursing units, to ensure that safe practices are being used.</li> <li>2. Implement the Immediate Action Plan and document outcomes.</li> <li>3. The facility needs to review its practices for identifying and</li> </ol>
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		reviewing Sentinel Events. 4. Continue to monitor this requirement.
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I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. The IRC and the independent SC reviewer have identified shortcomings in investigation reports. The IRC has returned some investigations requesting additional interviews or other work. The independent SC reviewer has raised in writing germane questions and concerns to which the OSI is expected to provide a response. In some instances, these questions/concerns have been helpful to the IRC in making recommendations.</li> <li>2. In general, the WRPTs have adequately implemented the DMH/facility's risk management procedure regarding the care of individuals who met a variety of high-risk triggers/thresholds. This included timely identification and adequate documentation of high-risk events and provision of timely and adequate levels of interventions that corresponded to the risk level. There was general evidence of positive clinical outcomes in these cases.</li> <li>3. The Quality Council minutes cited attention to MSH's Risk Management system. The minutes identified problems and issues that needed attention and the actions taken to address them. For example, substantial assistance was provided to the PRCs to assist them in conducting reviews with a more clinical focus.</li> <li>4. The hospital completed a study of those triggers that most often were the focus of ETRC referrals. It also conducted a before and after study of the efficacy of intervention by the FRC.</li> <li>5. The WRPs of individuals on behavioral high-risk lists addressed the aggressive behaviors. Most of WRPs reviewed of individuals on medical high-risk lists also addressed the named risk.</li> <li>6. The document <u>Analysis of Violence and Aggression at MSH</u> is a clear and comprehensive analysis of the subject matter that provides findings based on Key Indicator and incident data, identifies recommendations for responsive action and traces the status of these recommendations—some of which have been implemented and others of which are identified</li> </ol>

		<p>as "next steps." The full analysis has yet to be presented to the Quality Council soon.</p> <ol style="list-style-type: none"> <li>7. The Quality Council has determined that unexpected deaths will be reviewed at its meeting that follows the initial MIRC. It has also determined that workgroups will be expected to meet their due dates for reporting to the Council, without asking for deferments.</li> <li>8. As of the tour conducted in September 2010, MSH had maintained compliance with all of the requirements of Section J for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</li> </ol> <p><b>Areas of need include:</b></p> <ol style="list-style-type: none"> <li>1. <i>The integrity of the OSI investigations is open to question since interviews of central figures in the incidents under review were often interviewed months after the report of the incident. In one instance an individual could not remember making the allegation and in other instances one questions the clarity with which staff members claim to remember details of incidents that occurred 2-3 months earlier. The hospital reports that during the review period only 12% of the OSI investigations were completed within the timeline in the EP.</i></li> <li>2. <i>The response to two serious and similar incidents involving JL did not identify the factors that contributed to the incidents and did not identify actions to be implemented immediately to prevent a recurrence. This has resulted in JL still waiting for equipment to keep him safe and which will release him from bed-bound status.</i></li> <li>3. <i>In the sexual incidents reviewed, the facility's response did not meet the hospital's expectations that education, counseling and psychological assistance be provided to those involved. (The physical needs of the individuals were addressed.)</i></li> <li>4. <i>The WRPs of individuals on medical high-risk lists (falls, choking, and</i></li> </ol>
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		<p><i>decubitus) did not clearly document when the individual met criteria for high risk.</i></p> <ol style="list-style-type: none"><li><i>5. The executive director needs to improve oversight of the quality management system including, but not limited to, sentinel events and mortality reviews.</i></li><li><i>6. The facility must ensure timely and adequate implementation of the corrective actions that were initiated or are underway in response to recommendations of the Aggression Reduction Committee.</i></li></ol>
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1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. B. Ortega, Acting Hospital Administrator</li> <li>2. C. Loop, Supervising Special Investigator</li> <li>3. H. Mears, Chief of Hospital Police</li> <li>4. L. Dieckmann, PhD, Acting Director of Standards Compliance</li> <li>5. S. Smith Nevins, Executive Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Eight OSI investigations</li> <li>2. IRC minutes and task tracking form</li> <li>3. Documents related to the unexpected deaths of three individuals</li> <li>4. Training and other personnel information related to this section of the EP from HR for 13 staff members</li> <li>5. OSI Investigation log</li> <li>6. Incident reports for sexual assaults</li> <li>7. Seventeen Headquarters Briefs</li> <li>8. Clinical records of 10 individuals for most recent signing of rights notification</li> <li>9. Quality Council minutes</li> </ol>
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p><b>Compliance:</b> Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of	<p><b>Current findings on previous recommendation:</b></p>

	<p>individuals;</p>	<p><b>Recommendation, September 2010</b>  Implement as planned the recommendations of the IRC addressing the failure of staff to report incidents.</p> <p><b>Findings:</b>  The IRC reported a number of incidents of staff failing to report A/N/E allegations. It forwarded this concern to the Quality Council and it also conducted a small study of the reasons 22 staff failed to report. This study found that in several instances, staff member A believed that staff member B was going to report the allegation and neither one ensured the report was completed. Other staff reported they had other issues to attend to or did not recognize the event as a reportable incident. One staff member reported that (s)he "didn't want to get anybody in trouble."</p> <p><b>Other findings:</b>  Review of the material provided by HR for five staff members who failed to report A/N/E in the manner required by policy is reported in I.1.c.</p> <p><b>Current recommendation:</b>  Continue to address through training and disciplinary action the failure of staff to report incidents.</p>
<p>I.1.a.ii</p>	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b>  Continue current practice and monitoring.</p> <p><b>Findings:</b>  DMH Special Order 263: Incident Management System addresses all of the components of this section of the EP.</p> <p><b>Current recommendation:</b>  Continue current practice and monitoring.</p>

I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Ensure that the Medical Director and Clinical Administrator are provided adequate and correct information upon which to make the decisions to remove or not remove staff named in allegations of A/N/E.</p> <p><b>Findings:</b> The facility is following the directive in SO 263 in removing all staff members alleged to have engaged in physical abuse. If deemed appropriate, the DMH Allegation Checklist is completed by the Program Director through which he/she requests that the named staff member be returned to direct contact duties with individuals before the investigation of the incident is completed. This request is approved or denied by the Clinical Administrator and Medical Director. The checklist is included in the investigation packet that is reviewed by the IRC.</p> <p><b>Other findings:</b> In making the allegation of sexual assault (peer-to-peer) the victim, EM, said he wanted to be moved to another unit. The transfer was implemented immediately.</p> <p><b>Current recommendation:</b> Continue current practice of providing the checklist in the investigation material reviewed by the IRC to ensure a review of the equitable presentation of the information.</p>
I.1.a.iv	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring for compliance with attendance at annual A/N/E training.</p>

**Findings:**

As shown in the table below, 12 of the 13 staff members sampled had completed A/N/E training in the last 12 months.

Staff member*	Date of:			
	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training
_Z	1/3/05	11/24/04	1/3/05	2/16/11
_W	6/3/05	4/27/05	6/3/05	2/14/11
_C	1/2/09	11/21/08	1/2/09	1/20/11
_U	12/2/05	9/14/05	12/2/08	1/20/11
_W	9/6/05	7/28/05	9/6/05	1/13/11
_C	8/4/06	7/12/06	8/4/06	11/15/10
_O	7/7/00	5/26/00	7/7/00	11/15/10
_C	10/16/09	9/14/09	10/15/09	11/10/10
_K	9/15/05	8/17/05	9/15/05	9/15/10
_U	7/7/00	4/1/00	7/7/00	9/14/10
_H	1/9/98	12/23/97	1/9/98	6/14/10
_W	3/16/92	Update in process	3/16/92	6/1/10
_H	6/24/02	6/12/02	6/24/02	4/2/08

\*Only last initials are provided to protect confidentiality.

**Current recommendation:**

Continue to monitor attendance at annual training.

I.1.a.v

notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a

**Current findings on previous recommendation:****Recommendation, September 2010**

Continue to provide appropriate counseling and training to staff members who fail to report incidents in the manner required by policy.

	<p>statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p><b>Findings:</b> As provided in I.1.c, three of five staff members who failed to report A/N/E as required in policy did not receive counseling or training as a result, as reported by HR.</p> <p><b>Other findings:</b> In response to a number of instances of failure to report, the IRC conducted a small study of the reasons for not reporting. See I.1.a.i. The IRC discussed the issue in the 8/18/10 meeting and identified possible causes for not reporting that include lack of knowledge about the policy or in using the WaRMSS IM module, the perception that completing an incident report is too time-consuming, other disciplines' assumption that nursing staff will complete the reports, staff members trying to cover up incidents, and inadequate consequences for failure to report. The IRC referred the issue to the Quality Council and determined that it (IRC) would continue to review cases and look for patterns and systemic causes.</p> <p><b>Current recommendation:</b> Ensure that training and progressive discipline is provided to staff members who fail to report A/N/E in the manner required by policy.</p>
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Clarify the obligation of WRPTs to offer individuals the opportunity to discuss and sign the Statement of Rights annually.</p> <p><b>Findings:</b> As shown below, seven of the ten individuals sampled signed the statement of rights during the past 12 months. These findings are consistent with findings from an internal audit of four individuals on Unit 412, reported in the IRC minutes of 11/3/10, which found that all four had only signed the section of the form acknowledging receipt of the Rules and Regulations.</p>

		<table border="1" data-bbox="970 228 1541 651"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>VS</td> <td>3/7/11</td> </tr> <tr> <td>LK</td> <td>2/24/11*</td> </tr> <tr> <td>VF</td> <td>2/24/11*</td> </tr> <tr> <td>KB</td> <td>1/20/11 refused</td> </tr> <tr> <td>DM</td> <td>11/15/10</td> </tr> <tr> <td>MS</td> <td>10/5/10</td> </tr> <tr> <td>BJ</td> <td>9/2/10</td> </tr> <tr> <td>OS</td> <td>8/23/10</td> </tr> <tr> <td>JB</td> <td>5/6/10</td> </tr> <tr> <td>EM</td> <td>3/17/10</td> </tr> </tbody> </table> <p data-bbox="970 657 1877 748">*The top portion of the form is an acknowledgement of having received the Rules and Regulations; the bottom of the form is the notification of rights. Two individuals in the sample did not sign the bottom portion of the form.</p> <p data-bbox="955 797 1898 899"><b>Current recommendation:</b> Ensure that the notification of rights portion of the form is completed with the signature of the individual or a notation indicating refusal to sign.</p>	Individual	Date of most recent signing	VS	3/7/11	LK	2/24/11*	VF	2/24/11*	KB	1/20/11 refused	DM	11/15/10	MS	10/5/10	BJ	9/2/10	OS	8/23/10	JB	5/6/10	EM	3/17/10
Individual	Date of most recent signing																							
VS	3/7/11																							
LK	2/24/11*																							
VF	2/24/11*																							
KB	1/20/11 refused																							
DM	11/15/10																							
MS	10/5/10																							
BJ	9/2/10																							
OS	8/23/10																							
JB	5/6/10																							
EM	3/17/10																							
I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p data-bbox="955 943 1541 971"><b>Current findings on previous recommendation:</b></p> <p data-bbox="955 1016 1402 1044"><b>Recommendation, September 2010</b></p> <p data-bbox="955 1053 1283 1081">Continue current practice.</p> <p data-bbox="955 1127 1073 1154"><b>Findings:</b></p> <p data-bbox="955 1164 1692 1192">Each unit visited had a rights poster on a common area wall.</p> <p data-bbox="955 1237 1283 1265"><b>Current recommendation:</b></p> <p data-bbox="955 1274 1283 1302">Continue current practice.</p>																						
I.1.a. viii	procedures for referring, as appropriate, allegations of abuse or neglect to law	<p data-bbox="955 1352 1541 1380"><b>Current findings on previous recommendation:</b></p>																						

	<p>enforcement; and</p>	<p><b>Recommendation, September 2010</b>  Continue current practice of making appropriate referrals to law enforcement.</p> <p><b>Findings:</b>  On 10/9/10, EM was banging his head on the door of the nurses' station. When asked why he was upset, he said (in street language) that he had been sodomized. He was offered an assessment by the nurse and by the physician—both of which he refused. HPD was not notified. On 10/13, EM made a complaint to Disability Rights again alleging the rape and stating that staff were told and "they didn't do anything. The police wasn't informed." As a result, on 10/13/10 the HPD was informed. The OSI investigation recommended that the unit staff member receive training on reporting A/N/E and that the HPD officer, who failed to follow Penal Code requirements for reporting sex crimes, receive training on completing the required forms.</p> <p>This case was originally considered a neglect incident because EM in reporting the assault said he told staff and they did nothing. When it was found that the staff had offered nursing and medical assistance, the neglect charge was dropped on the advice of Standards Compliance.</p> <p>There are circumstances in which the failure to report an alleged crime to HPD reaches the level of neglect. This is one of those instances, as EM was alleging a recent event and was so distraught as to be banging his head on the door in response to the assault, and was requesting to be moved off the unit.</p> <p><b>Other findings:</b>  The facility reported that during the review period, five individuals were charged and arrested for felony assault and/or battery charges.</p>
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		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that all alleged crimes are reported expeditiously to HPD.</li> <li>2. Continue working with the District Attorney's office to bring charges against individuals when this is appropriate.</li> </ol>
I.1.a.ix	<p>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.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and maintain vigilance in identifying situations where retaliation may be likely.</p> <p><b>Findings:</b> In the investigation reports reviewed, there were no situations in which retaliation would be likely.</p> <p><b>Current recommendation:</b> Continue to monitor incidents to identify situations in which retaliation may be likely.</p>
I.1.b	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p><b>Compliance:</b> Partial.</p>
I.1.b.i	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Make efforts to meet the timelines for the completion of reviews in the SO.</p> <p><b>Findings:</b> See findings in I.1.b.iv.2. Further work is required to meet the timelines in the EP.</p>

	<p>persons with mental disorders;</p>	<p><b>Other findings:</b>  Three individuals died unexpectedly in the review period. As indicated below, autopsy reports for two of these individuals had not been sent to MSH at the time of the CM review. These unexpected deaths were reviewed at the January 13 Quality Council meeting, where the issue of untimely autopsy reports and untimely OSI reports was raised.</p> <ul style="list-style-type: none"> <li>• IG was 57 years old when he died on 12/15/10. The Internal Death Review (undated) conjectured that the cause of death was likely massive MI or sleep apnea. The MIRC (12/28/10) noted that the Medical Death Summary was incomplete and should be redone. It further noted that relevant portions of the clinical record were missing and were being searched for at the time of the meeting. The Independent External Review and the autopsy report were pending at the time and had not yet been received by the time of this CM review.</li> <li>• HF was 67 years old when he died on 9/26/10. The MIRC (10/7/10) cites facts provided in a verbal report by OSI stating the suspected cause of death as foreign body aspiration (pieces of chicken), airway obstruction. The physicians present disagreed, since HF died several hours after he had his last meal (chicken). The External Medical Review (11/13/10) was completed prior to the autopsy report and noted that any reference to cause of death would be speculative. It offered strong praise for the psychiatric and medical documentation and care. It noted that all executive team members were excused/absent from the MIRC and urged immediate corrective actions related to dietary procedures to ensure food provided to individuals is the correct texture. It questioned why OSI could not provide a preliminary written report, since it was able to provide a verbal report to the committee. The Coroner's report received later determined the cause of death as asphyxia due to choking on food.</li> <li>• OS suddenly died on 9/11/10 at the age of 21. At the time of this report, the OSI investigation report and the autopsy report had not yet</li> </ul>
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		<p>been received. The Independent External Review (10/13/10) describes the event of 8/30/10 when OS was pacing the hall, fell, and appeared to have a seizure. Staff responded, took vital signs, the MOD and EMS arrived and instituted ACLS measures. OS was transported to the hospital and treated in ICU. He gradually developed multi-system failure and was declared dead on 9/11/10. The Independent Reviewer questioned the lack of a preliminary OSI written report, and asked that additional information be included in the Nursing Death Summary. The Independent External Review offers several pages of recommendations that include:</p> <ul style="list-style-type: none"><li>➤ Taking direct action with those individuals sent to MSH with a court order for involuntary medication and refusing medication;</li><li>➤ Determining the hospital policy regarding permitting individuals to remain up at night and pace the unit out of sight of nursing staff;</li><li>➤ Determining the performance improvement steps to be taken when an individual is refusing lab testing related to the psychoactive medication he is receiving; and</li><li>➤ Reviewing nursing procedures to allow nursing to deliver oxygen at a rate above 3L/minute, if the review proves the change advisable.</li></ul> <p>At the time of the onsite visit, the facility was still awaiting the autopsy report.</p> <p>During the review period, eight MIRC meetings were convened. The Executive Director did not attend these meetings. The Medical Director attended six meetings and at the other two, the Assistant Medical Director chaired the meeting in his place. The Chief of Medical Services attended seven of the meetings.</p> <p>The Quality Council discussed MIRC reviews of unexpected deaths at its December 23 meeting. The minutes state that the QC agreed that all MIRC cases will be reviewed by the QC at the first meeting following the date of the first MIRC review. The Medical Director, Chief of Medical Services and the Nurse Administrator will "ensure that a preliminary review is completed</p>
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		<p>for all unexpected deaths that will be initiated within 24 hours [of the death] as instructed by the ED." The Medical Director and the Chief of Medical Services will be responsible for presenting the cases to the QC.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue efforts to obtain autopsy reports in a timely manner.</li> <li>2. Ensure that the ED attends MIRC meetings.</li> <li>3. Implement plans for a timely review of unexpected deaths by the QC.</li> </ol>
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue the practice of an independent review of A/N/E investigations until it proves unnecessary.</p> <p><b>Findings:</b> The facility has maintained the independent review of A/N/E investigations.</p> <p><b>Other findings:</b> Investigations of A/N/E and Internal Affairs investigations are conducted by Special Investigators, who have received training. Other investigations are conducted by Police Investigators, who have received Police Academy training.</p> <p><b>Current recommendation:</b> Continue the independent review of OSI investigations until it proves unnecessary.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> When photos are taken, document this in the investigation report and note that they were placed in an evidence locker or its equivalent.</p>

		<p><b>Findings:</b> The IRC noted in its review of the investigation of the allegation of physical abuse of JG that the HPD should take photos even when there is no apparent injury. During the investigation of the assault on a male nurse by JN, a female individual in care, the HP officer failed to take photos of the victim of the battery. In the investigation of the allegation of neglect of AL, the investigator took pictures of AL's injuries resulting from an accidental fall in the bathroom.</p> <p><b>Current recommendation:</b> Note in the investigation reports that physical evidence has been placed in a secure setting.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue to review the quality of investigations, both by the Supervising Special Investigator and the independent SC reviewer.</p> <p><b>Findings:</b> The investigations reviewed were approved by the Supervising Special Investigator as indicated by his signature. Comments from the independent SC reviewer were attached to several of the investigation reports reviewed. For example, in the investigation of the physical abuse of NR (8/30/10) in which he alleged that staff walked into his bedroom in the morning and punched him several times, the SC independent reviewer raised questions and concerns about the practice of using individuals to accompany staff to awaken other individuals, given the risk of violence. The SC independent reviewer advised that this practice be addressed systemically.</p> <p><b>Other findings:</b> Several of the investigations reviewed did not follow standard practice in</p>

		<p>completing interviews expeditiously and thereby compromised the integrity of the investigations. Examples include:</p> <ul style="list-style-type: none"> <li>• In the investigation of the physical abuse of NR (reported to OSI on 8/30/10), the two staff members named as the alleged perpetrators were interviewed on 11/29/10 and 12/2/10, three months after the event.</li> <li>• The physical abuse allegation made by JS on 8/13/10 rested on her assertion that she was told by staff that she could not go to lunch and was then denied food. The interviews of the four named staff members began on 11/3 and concluded on 11/10/10, almost three months after the report of the incident.</li> </ul> <p><b>Current recommendation:</b> Conduct interviews as proximate to the report of the allegation as possible.</p>
I.1.b. iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010</b> Continue current practice of HPD timely response to allegations of A/N/E.</p> <p><b>Findings:</b> HPD continued to respond in a timely manner when notified of an A/N/E allegation.</p> <p><b>Recommendation 2, September 2010</b> Conduct interviews as near to the report of the incident as possible.</p> <p><b>Findings:</b> See findings in the cell above. Delays in proceeding with interviews were problematic in several investigations reviewed.</p>

		<p><b>Current recommendation:</b> Continue current practice of HPD's timely response to the report of an A/N/E allegation.</p>
I.1.b. iv.2	<p>investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Monitor open cases closely to determine if there is an identifiable point at which investigations fail to make progress and provide necessary guidance/assistance.</p> <p><b>Findings:</b> In the investigation reports reviewed, a pattern emerged that explains, at least in part, the lack of timely completion. In several cases, months elapsed between interviews or between the last interview and the submission of the report for approval. For example:</p> <ul style="list-style-type: none"> <li>• DOI: 8/30/10; individual interviewed 8/30/10; all subsequent interviews conducted in November and December; two named staff interviewed on 11/29 and 12/2. Case closed on 2/8/11.</li> <li>• DOI: 8/13/10; individual interviewed 8/24; other interviews conducted in November. Case closed on 12/3/10.</li> <li>• DOI: 6/19/10; individual interviewed 7/19; all other interviews conducted in July, August and September. Case closed 11/7/10.</li> <li>• DOI: 8/23/10; reported to OSI on 8/30/10. First OSI interview 9/30/10.</li> </ul> <p><b>Other findings:</b> One of the OSI investigations reviewed was completed in the 30 business day EP timeframe. This finding is consistent with the facility's own data, which finds that 12% of the OSI investigations were completed within the EP timeframe during this review period.</p>

		<table border="1"> <thead> <tr> <th>Incident type</th> <th>Date reported</th> <th>Date to OSI</th> <th>Date Closed</th> <th>30 Business Days?</th> </tr> </thead> <tbody> <tr> <td>Physical Abuse</td> <td>8/30/10</td> <td>8/30/10</td> <td>2/8/11</td> <td>No</td> </tr> <tr> <td>Sexual Assault</td> <td>10/9/10</td> <td>10/13/10</td> <td>11/1/10</td> <td>Yes</td> </tr> <tr> <td>Verbal Abuse</td> <td>9/29</td> <td>10/15 1<sup>st</sup> interview</td> <td>11/29</td> <td>No</td> </tr> <tr> <td>Sexual Abuse</td> <td>7/13/10</td> <td>8/17</td> <td>9/29/10</td> <td>No</td> </tr> <tr> <td>Physical Abuse</td> <td>8/13/10</td> <td>8/16/10</td> <td>12/3/10</td> <td>No</td> </tr> <tr> <td>Physical/Psychological Abuse</td> <td>8/23/10</td> <td>8/30/10</td> <td>12/20/10</td> <td>No</td> </tr> <tr> <td>Physical Abuse</td> <td>10/11/10</td> <td>10/13/10</td> <td>11/29/10</td> <td>Not quite</td> </tr> <tr> <td>Neglect</td> <td>6/19/10</td> <td>6/23/10</td> <td>11/7/10</td> <td>No</td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Initiate procedures to advance the timeliness of completion of investigation reports.</p>	Incident type	Date reported	Date to OSI	Date Closed	30 Business Days?	Physical Abuse	8/30/10	8/30/10	2/8/11	No	Sexual Assault	10/9/10	10/13/10	11/1/10	Yes	Verbal Abuse	9/29	10/15 1 <sup>st</sup> interview	11/29	No	Sexual Abuse	7/13/10	8/17	9/29/10	No	Physical Abuse	8/13/10	8/16/10	12/3/10	No	Physical/Psychological Abuse	8/23/10	8/30/10	12/20/10	No	Physical Abuse	10/11/10	10/13/10	11/29/10	Not quite	Neglect	6/19/10	6/23/10	11/7/10	No
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I.1.b. iv.3	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Critically review investigations to ensure that rationales for determinations are provided and build upon the incident definitions in Special Order 263.</p> <p><b>Findings:</b> Please see the first finding in I.1.b.iv.3(ix) for discussion of a very good investigation summary. In contrast to the summary cited in I.1.b.iv.3(ix), the summary in the investigation of the physical abuse of NR runs for four pages and is a re-presentation of the each of interviews conducted.</p> <p><b>Other findings:</b> Several of the investigation reports reviewed included appropriate recommendations for corrective actions beyond a referral of staff for training or discipline. For example, the investigator recommended that</p>																																													

		<p>dietary staff have available to them prior to the service of food the physician's orders for those individuals who are permitted coffee. At the conclusion of the investigation of the physical abuse of NR, the investigator recommended the implementation of a new process for the exchange of pertinent information from the outgoing to the incoming MOD or POD.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Work to make investigation summaries a crisp and concise summary of salient facts taken into consideration in making the determination.</li> <li>2. Continue the practice of making recommendations for programmatic and systemic changes in investigation reports.</li> </ol>
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Ensure that investigations address all allegations made or coded in the reporting of an incident.</p> <p><b>Findings:</b> In the investigations reviewed, there was evidence of attention to the need to investigate allegations embedded in other allegations. For example, when on 10/11/10 AB made an allegation of physical abuse, he also alleged that he asked for a complaint form and was not provided one. The investigator reviewed this allegation and interviewed the staff member, who reported providing AB with the form.</p> <p><b>Current recommendation:</b> Continue current practice of addressing all allegations made in a complaint or during an investigation.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	<p><b>Current findings on previous recommendation:</b></p>

		<p><b>Recommendation, September 2010</b> Continue current efforts to identify all possible witnesses to an incident.</p> <p><b>Findings:</b> When the allegation of physical abuse of AB was reported, the Program Assistant spoke with two individuals, MB and LJ, in an effort to identify individuals who may have witnessed the incident.</p> <p>In contrast, during the investigation of the alleged sexual assault of EM, the victim told investigators that when the assault occurred he informed three staff members, whom he identified by name. One of the staff members actually worked the evening of the assault; the other two did not. OSI did not interview the one staff member correctly named by the victim, nor did OSI interview any other staff members on duty the evening of the assault.</p> <p><b>Current recommendation:</b> Interview all individuals and staff identified as having a role in an incident alleging A/N/E.</p>
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> All investigation reports reviewed clearly identified the alleged victims and perpetrators.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p>

		<p><b>Recommendation, September 2010</b> Provide a careful review of investigations by the Supervising Special Investigator, the independent reviewer, and the IRC.</p> <p><b>Findings:</b> Please see I.1.b.iv.4 for discussion of the positive work of the IRC and the cell below for positive work of the independent reviewer.</p> <p><b>Other findings:</b> The investigation reports reviewed identified the names of all persons interviewed and provided a summary of the interviews. The exception is discussed below.</p> <p><b>Current recommendation:</b> Continue the careful review of investigations by all parties responsible for this work.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> The interviews of the Subject Matter experts, in this case, physicians in leadership positions, were not conducted in a manner that ensured appropriate direct questions were asked and answered. Specifically, AL said she was not provided adequate medical care after she fractured two ribs when she fell in the bathroom. She alleged that she requested to see a doctor and wanted an ambulance, but staff ignored her requests. The conclusion section of the investigation report states that the investigator spoke to the supervisor of the physicians alleged to have provided inadequate care and with the Medical Director, "who found no problem with the staff's handling of the incident." The investigator subsequently</p>

		<p>determined that the allegation of neglect against the physicians and other staff was not sustained, but in the Recommendations section of the report, posed two questions: Should physician A have examined AL personally and not just prescribed Tylenol over the phone? Should physician B have checked on AL's condition, either personally or by phone, before completing the shift?</p> <p>The SC independent reviewer made several salient points. She noted that the 'not sustained' determination "seems to depend on their [the leadership physicians consulted] conclusions which were not spelled out in any detail." She further stated that the two questions should be covered in the body of the report and questioned why they could not be posed directly to the consulting physicians or, if they were, what was their response. In response to these observations, the Special Investigator claimed that the two physicians consulted did not respond to his requests for follow-up. The IRC reviewed the investigation report during the 12/8/10 meeting and recommended that a third physician in a leadership position review the case and take appropriate action based on his findings.</p> <p>In contrast, the investigation of the alleged physical abuse of NR found that NR was restrained in prone position for 4-5 minutes and no attempt was made to move him from prone position. A Master TSI trainer was interviewed and her complete response, the core of which was that staff are taught to remove an individual from prone position as soon as possible, is clearly documented.</p> <p><b>Current recommendation:</b> Take care to present clearly the questions posed to and the response by Subject Matter Experts. Quote the SMEs' responses precisely.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<b>Current findings on previous recommendation:</b>

		<p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> Each of the investigation reports reviewed including a listing of all documents reviewed. Each also included a copy of the individual's WRP. It was agreed in discussion that when the WRP was not referenced in the investigation as supplying useful information and since the WRP is now available electronically, it is no longer a necessary use of resources to copy and distribute WRPs with each investigation report.</p> <p><b>Other findings:</b> On 8/13/10, JS alleged that she was denied lunch. The investigation report on this allegation included copies of the IDNs written by two staff stating that although JS was not permitted to go to the dining room because she was too agitated, she was offered a meal tray on the unit. This practice conforms to current standards.</p> <p><b>Current recommendation:</b> As agreed, discontinue the practice of including the WRPs of the victim in every investigation report. Provide this document only when it is integral to the investigation.</p>
I.1.b. iv.3 (vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice of reviewing staff member's history of having been named in A/N/E allegations. Do not limit the review to sustained cases.</p> <p><b>Findings:</b> Please see the findings in I.1.d.ii describing the facility's practices as seen in the investigation reports reviewed and its plan for meeting the expectations of this section of the EP.</p>

		<p><b>Current recommendation:</b> Continue to monitor compliance with this requirement of the EP.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue to identify breaches of policy in investigations.</p> <p><b>Findings:</b> The investigator identified several breaches of policy during the investigation of the allegation of physical abuse make by NR. These include:</p> <ul style="list-style-type: none"> <li>• Staff members' failure to report the incident in the manner required by policy;</li> <li>• Physician's failure to adequately document the individual's response to Stat and PRN medications;</li> <li>• Use of prone restraint; and</li> <li>• Failure of HSS to conduct an independent assessment of an individual's change in status when responding to an incident.</li> </ul> <p><b>Other findings:</b> As reported above, the investigation of the allegation by JS that she was denied food (physical abuse) did not sustain the allegation, stating that JS was provided a lunch tray on the unit. The investigation packet includes the IDNs stating that JS was offered a lunch tray, which she refused. However, the investigation report does not specifically reference those notes and does not identify who provided the tray. Thus, while the preponderance of the evidence does, in fact, indicate that JS was offered a meal, this conclusion does not rest on facts presented in the body of the investigation report.</p>

		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that conclusions are founded on facts presented in the body of investigation reports.</li> <li>2. Continue to identify breaches of policy in investigations.</li> </ol>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Ensure a strong supervisory review of the conclusions drawn in investigations.</p> <p><b>Findings:</b> The Findings/Conclusion section of the report of the investigation of the allegation of physical abuse made by AB (10/11/10) is the strongest among the investigation reports reviewed. Specifically, it rests the 'not sustained' determination on three specific facts.</p> <ul style="list-style-type: none"> <li>• Identified witnesses, both staff and individuals, did not support the allegation that the named staff member hit the victim on the hand.</li> <li>• The named staff member had not responded to the victim's claim that they should marry when he got out as he had hoped.</li> <li>• The victim was upset because he was denied coffee (must have a physician's order). This could be viewed as motive to make the allegation.</li> </ul> <p>In contrast to the exemplary work in drawing on facts to undergird a determination, the Program Assistant review of the allegation of sexual assault made by EM contains information that is contradicted in the investigation report. The Program review states that the two individuals live in separate dorms, but the investigation report states they are roommates. The Program review states that the alleged victim "appeared to be in no distress", but the investigation report and the physician's IDN state that he was banging his head on the nurses' station and, when questioned about what</p>

		<p>was upsetting him, made the sexual assault allegation. The Program review stated that the alleged victim "never denied [the alleged perpetrator's] claim that the act was consensual", yet, the initial allegation was clearly one of sexual assault, not consensual activity. It is unclear why the supervisor/Program Assistant review was not corrected.</p> <p>The IDN notes written by staff on August 18 and 19 that report JS's allegation of rape made to Disability Rights on 8/18/10 are "cut and copies." The 10:54 and 11:28 notes on 8/18 and the 7:02 note on 8/19 are identical. This practice should be identified as unacceptable.</p> <p><b>Current recommendation:</b> Identify in investigation reports errors and other deficiencies in documents that are relied upon as a source of information in an investigation.</p>
I.1.b. iv.4	<p>staff supervising investigations review the written report, together with any other relevant documentation, 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. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue the independent review of investigations until the capacity to critically critique and improve investigations is developed within OSI.</p> <p><b>Findings:</b> MSH continued the independent review of investigations. These reviews are referenced in the IRC minutes. See I.1.b.iv.3(v) for an example of the assistance provided by the independent reviewer in identifying additional work needed on a case.</p> <p><b>Other findings:</b> The minutes of the IRC meetings indicate that the Committee is providing a thoughtful review of the quality of the investigation reports reviewed. Examples include the following observations by the Committee:</p> <ul style="list-style-type: none"> <li>• August 11 meeting—Reminded HPD of the need to take photos of</li> </ul>

		<p>injuries, even if none are apparent.</p> <ul style="list-style-type: none"> <li>• August 26 meeting—The investigator stated that an individual's account was not credible because he/she was delusional. The Committee asked that the statement be removed because it was based on documentation about symptoms the individual reported before coming to MSH.</li> <li>• Sept 22 meeting—A neglect investigation report was returned to OSI because the neglect issue was not adequately addressed.</li> <li>• December 22 meeting—The investigator was requested to re-interview a staff member regarding the named staff member's IDN.</li> <li>• January 19 meeting—The IRC overturned the unfounded and not sustained determinations in the investigation of the case involving a nurse unnecessarily administering medications to an individual in three different syringes. The IRC determined that the unnecessary injection was physical abuse and that the staff intended to deceive NK about her medications, an action that constituted psychological abuse.</li> </ul> <p>There is a statement in the IRC minutes stating whether each case under review met the EP timeframes.</p> <p>The Executive Director served as the Chair of the IRC for most of the meetings. On those few occasions when she was not present, the Medical Director served as the Chair.</p> <p><b>Current recommendation:</b> The IRC should continue the current practice of thoughtful review of the quality and timeliness of investigation reports.</p>
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring.</p>

**Findings:**

Disciplinary Action

A total of five staff members, involved in two incidents, were found to have failed to report an allegation of A/N/E in a manner prescribed in policy. The follow-up actions reported below were provided by HR.

Incident type	Date of Incident	Corrective Actions
Verbal Abuse	2/22/10 Closed 7/19/10	TSI training for each of three staff members. No actions related to failure to report.
Sexual Abuse	7/13/10 Closed 9/29/10	One of two staff received training on AD Reporting Responsibilities. Same training for second staff is recommended but not yet conducted.

During the investigation of an allegation of neglect, the licensed staff member whose actions were under review failed to cooperate with the investigation by canceling or not appearing for scheduled interviews. Corrective action, according to HR, was a verbal discussion with the staff member. This minimal response opens the question of whether a staff member of lesser rank would have been treated in the same manner.

In the sustained allegation of psychological and physical abuse (incident date: 8/23/10) the named staff member has an adverse action pending.

**Other findings:**

Programmatic Action

On 8/11/10, WH threw himself backwards in a stairwell, resulting in a head injury that left him temporarily unresponsive. WH has a history of self-abuse at MSH. The DPH cited the facility in August 2010, noting that WH

		<p>often banged his head on sharp objects, slammed his fingers in doors repeatedly and dived from furniture face down onto the floor. During many of these incidents he was under direct 1:1 supervision, which was ineffective in preventing his self-injury because MSH policy forbids a single staff member to physically intervene, i.e., he/she is not allowed to place hands on an individual by him/herself. Staff interviews by DPH found there was no facility policy for ordering 2:1 observation.</p> <p>The POC submitted by MSH dated 2/7/11 addressing systemic issues states that AD 3355 will address placing individuals on higher levels of observation and provide immediate protection from harm. This will include, but not be limited to, appropriate staffing ratios; locked seclusion with continuous 1:1 observation; and use of mittens, head gear and any other measures deemed necessary by the Medical Director after a thorough evaluation and consultation with the treating clinician and senior psychiatrist. The use of all measures beyond those in the AD will require the approval of the Medical Director.</p> <p>See also I.2.c for other programmatic actions taken in response to the analysis of incident data.</p> <p><b>Compliance:</b> Partial, due to concerns regarding the response to failure to report and failure to cooperate with an investigation.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that HR is aware of all measures taken in response to a staff member's failure to report A/N/E.</li> <li>2. Remain alert to the question of equitability in assigning counseling/disciplinary actions.</li> </ol>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results.	<b>Compliance:</b> Substantial.

	Trends shall be tracked by at least the following categories:																													
I.1.d.i	type of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue the facility's focus on increasing the safety of individuals in care.</p> <p><b>Findings:</b> The <u>Analysis of Violence and Aggression at MSH</u> document provides counts of aggression by type for the review period (August 2010 - January 2011). This data indicates a spike in all forms of aggression (except verbal aggression to staff) in January. During the review period, 19 incidents of sexual assault (peer-on-peer) were reported.</p> <table border="1"> <thead> <tr> <th>Aggression type</th> <th>Total</th> <th>Range</th> <th>Low/High Month</th> </tr> </thead> <tbody> <tr> <td>Physical to Peer</td> <td>500</td> <td>67-100</td> <td>Nov/Jan</td> </tr> <tr> <td>Verbal to Peer</td> <td>36</td> <td>1-12</td> <td>Nov/Jan</td> </tr> <tr> <td>Physical to self</td> <td>325</td> <td>41-68</td> <td>Sept/Jan</td> </tr> <tr> <td>Physical to staff</td> <td>191</td> <td>24-50</td> <td>Sept/Jan</td> </tr> <tr> <td>Verbal to staff</td> <td>24</td> <td>2-7</td> <td>Aug, Nov/Oct</td> </tr> <tr> <td>Total</td> <td>1076</td> <td></td> <td></td> </tr> </tbody> </table> <p><b>Current recommendation:</b> Continue to present incident and aggression data to the Quality Council for review and action.</p>	Aggression type	Total	Range	Low/High Month	Physical to Peer	500	67-100	Nov/Jan	Verbal to Peer	36	1-12	Nov/Jan	Physical to self	325	41-68	Sept/Jan	Physical to staff	191	24-50	Sept/Jan	Verbal to staff	24	2-7	Aug, Nov/Oct	Total	1076		
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I.1.d.ii	staff involved and staff present;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Ensure that investigations list all A/N/E incidents in which the staff member has been named as the subject. It is appropriate to also provide</p>																												

		<p>the determination; however, do not limit the listing to sustained cases.</p> <p><b>Findings:</b> The September 22, 2010 IRC minutes of the review of the investigation of the physical abuse allegation made by CG note the committee's decision that a new report will be developed that will list all allegations in which a staff member has been named. This list is generated using WaRMSS and is not limited to sustained cases. The facility provided an example of how this list was used in a case in which a staff member worked in a unit where many individuals made false allegations and hence the staff member's name appeared repeatedly.</p> <p><b>Other findings:</b> In the investigation reports reviewed (approved before the work described above was completed), reporting on the involvement of staff in other incidents was inconsistent. For example:</p> <ul style="list-style-type: none"><li>• The incident history of all five named staff was provided in the investigation report of the alleged neglect of AL.</li><li>• In the investigation report of the alleged physical abuse of NR, only prior abuse allegations were noted.</li><li>• Two named staff members in the investigation of the physical abuse of JM were noted to have had no adverse actions or rights complaints.</li></ul> <p>Lowering the bar to limit the review to adverse actions retards the identification of trends and patterns until the staff member has already engaged in serious misconduct or mistreatment.</p> <p><b>Current recommendation:</b> Implement, as planned, the listing of all the allegations in which staff members have been named.</p>
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I.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> The investigation reports reviewed included a data run of the incident involvement of the alleged victims.</p> <p><b>Current recommendation:</b> Continue current practice.</p>									
I.1.d.iv	location of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> The <u>Analysis of Violence and Aggression at MSH</u> document identified the location of acts of aggression that reached trigger thresholds during the period March 2010 to January 2011. As shown, Units 412, 414 and 416 were the sites of the greatest number of acts of aggression that reached trigger thresholds. These units are in Program II, which houses LPS Conservatees. The analysis further stated that Program II is comprised of the largest percentage of individuals with Axis II Antisocial and Borderline Personality Disorder diagnoses.</p> <table border="1" data-bbox="957 1192 1850 1416"> <thead> <tr> <th data-bbox="957 1192 1352 1268">Trigger</th> <th data-bbox="1352 1192 1591 1268">Unit w/ highest incidence</th> <th data-bbox="1591 1192 1850 1268">Unit w/ next highest incidence</th> </tr> </thead> <tbody> <tr> <td data-bbox="957 1268 1352 1344">Aggression to self with major injury</td> <td data-bbox="1352 1268 1591 1344">416 with 68 acts</td> <td data-bbox="1591 1268 1850 1344">412 with 16 acts</td> </tr> <tr> <td data-bbox="957 1344 1352 1416">2 or more aggressive acts to self in 7 days</td> <td data-bbox="1352 1344 1591 1416">416 with 39 acts</td> <td data-bbox="1591 1344 1850 1416">412 with 24 acts</td> </tr> </tbody> </table>	Trigger	Unit w/ highest incidence	Unit w/ next highest incidence	Aggression to self with major injury	416 with 68 acts	412 with 16 acts	2 or more aggressive acts to self in 7 days	416 with 39 acts	412 with 24 acts
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I.1.d.v	date and time of incident;	<p>The document provides further analysis of patterns and trends on units 412, 414 and 416, noting the decreasing trend in aggression to others in all three units over the March 2010 to January 2011 period.</p> <p>MSH analysis of incident data for the current review period found that hallways, bedrooms and day halls were the scenes of the greatest number of incidents, as one would expect. Hallways saw 372 incidents, bedrooms 210, and day halls 193. Not surprisingly, bathroom and bedroom locations accounted for 57% of the incidents of aggression to self.</p> <p><b>Current recommendation:</b> Continue data presentation and analysis.</p> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> The data analysis presented in <u>Analysis of Violence and Aggression at MSH</u></p>																				

		<p>indicates that the number of aggressive incidents during waking hours (7AM-10PM) during the review period (August 2010-January 2011) ranged from 25 to 89. The lowest count occurred at 10:00 PM and the highest at 5:00 PM. The time period between 4:00 PM-8:00PM saw the greatest number of incidents of aggression/violence.</p> <p><b>Current recommendation:</b> Continue current practice of incident data analysis.</p>
I.1.d.vi	cause(s) of incident; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Ensure that the narrative description of an incident matches the incident type code.</p> <p><b>Findings:</b> Seventeen Headquarters Briefs were reviewed. In 14, the description of the incident matched the code assigned to the incident. The remaining three briefs had the following problems:</p> <ul style="list-style-type: none"> <li>• The 12/21/10 incident involving SP was correctly coded for the allegation of neglect, but was not coded for the allegation of sexual harassment by a peer.</li> <li>• The 12/12/10 incident in which MB alleged physical abuse was incorrectly coded as verbal abuse.</li> <li>• The 12/17/10 incident involving HL was correctly coded for his aggression toward staff, but was incorrectly identified as an allegation of abuse.</li> </ul> <p><b>Other findings:</b> As noted above, MSH found a correlation between individuals with the Axis II diagnoses antisocial and borderline personality disorders and aggressive acts to self and others.</p>

		<p>The facility found that a significant number of aggressive incidents were related to contraband, particularly tobacco, coffee, electronics, and illicit substances. In response, the facility is evaluating the possibility of increasing the frequency of contraband searches in both the LPS and Forensic compounds.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice of incident data analysis, identifying factors that appear to contribute to violence/aggression.</li> <li>2. Ensure that the narrative description of an incident and the incident type code match.</li> </ol>
I.1.d. vii	outcome of investigation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Keep the OSI log updated to reflect correctly determinations.</p> <p><b>Findings:</b> The OSI log was not corrected to reflect the IRC determination that the 8/23/10 allegations of psychological and physical abuse were sustained. The investigation had determined them not sustained.</p> <p><b>Other findings:</b> According to the OSI Investigations Case Log, 34 of the 92 investigations opened during the review period had been closed as of 3/2/11. One case of exploitation was sustained; the remaining cases were not sustained or were unfounded. Violations of policies or procedures were found in several not sustained cases.</p> <p><b>Current recommendation:</b> Continue to maintain the OSI log as presently constructed with the status of the investigations identified.</p>

I.1.e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. 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 a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p> <p><b>Findings:</b> As shown in I.1.a.iv, all of the staff members sampled had cleared the background check prior to their date of hire. The background check for one staff member is being updated.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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2. Performance Improvement		
I.2	<p>Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. A. Carol Abkarian, PsyD, Unit Psychologist</li> <li>2. Adonis Sfera, MD, Staff Psychiatrist</li> <li>3. Alex Guerrero, PsyD, Unit Psychologist</li> <li>4. Amy Choi, PhD, Unit Psychologist</li> <li>5. Andrew Erman, Clinical Social Worker</li> <li>6. Anna Peek, PsyD, Senior Psychologist</li> <li>7. Ashvind N. Singh, PhD, Treatment Enhancement Coordinator (QC)</li> <li>8. Bala Gulasekaram, MD, Chief of Psychiatry (QC)</li> <li>9. Becky Martinez, Psychiatric Technician</li> <li>10. Calixto Verdin, Psychiatric Technician</li> <li>11. Carmen Fayloga, Health Service Specialist (QC)</li> <li>12. Carolyn Sabol, Rehabilitation Therapist</li> <li>13. Charlene Bolding, Rehabilitation Therapist</li> <li>14. Cindy Huang, PhD, Unit Psychologist</li> <li>15. Corazon Ollada, Registered Dietician</li> <li>16. David Estrada, MD, Staff Psychiatrist</li> <li>17. Debbie Mammen, Psychiatric Technician</li> <li>18. Debra Hughes, Unit Supervisor</li> <li>19. Demetrius Stearns, Unit Supervisor</li> <li>20. Elisa Espiritu, Nurse Practitioner, Standards Compliance (QC)</li> <li>21. Eugene Moynier, Psychologist</li> <li>22. Fatimah Busran, Licensed Clinical Social Worker</li> <li>23. Foresteen Forbes, PsyD, Unit Psychologist</li> <li>24. Heather Spencer, Clinical Social Worker</li> <li>25. Ie-Hwa Wu, Registered Nurse</li> <li>26. Jasjih Kaur, MD, Staff Psychiatrist</li> <li>27. Jeff King, Rehabilitation Therapist</li> <li>28. Jeffry Rea, PsyD, Unit Psychologist</li> <li>29. Jennifer Gaskell, Rehabilitation Therapist</li> </ol>

		<p>30. Jesus Guerro, Psychiatric Technician  31. Karen Chong, Acting Clinical Administrator (QC)  32. Kasia Kolasinski, Health Services Specialist, Risk Manager (QC)  33. Keven Buckheim, Assistant Treatment Enhancement Coordinator  34. Kristin Arden, Registered Nurse  35. Laura Dardashti, MD, Staff Psychiatrist  36. Leah S. Abarientos, Registered Nurse  37. Lee Breitenbach, Clinical Social Worker  38. Lena Wong, Licensed Clinical Social Worker  39. Linda Gross, Nursing Coordinator (QC)  40. Lisa Bralliar, Registered Nurse  41. Lisa Dieckmann, PhD, Standards Compliance Psychologist (QC)  42. Marta Gomez, Registered Nurse  43. Michael Barsom, MD, Medical Director (QC)  44. Michael Simmons, Licensed Clinical Social Worker  45. Michele DeTrinidad, Registered Nurse  46. Miyuki Ogra, Rehabilitation Therapist  47. Murni Lubis, MD, Staff Psychiatrist  48. Nady Hanna, MD, Assistant Medical Director (QC)  49. Nati Medirano, Registered Nurse  50. Nibkshi Sanaguru, PsyD, Unit Psychologist  51. Peter Han, Clinical Social Worker  52. R. Flores, Supervisor of Vocational Services  53. Rimborto Gonzalez, Psychiatric Technician  54. Robert Lindstrom, MD, Staff Psychiatrist  55. Ronda Davenport, Program Director  56. Sharon Smith Nevins, Executive Director, Quality Council (QC chair)  57. Sheri Greve, PsyD, Acting Chief of Psychology (QC)  58. Terrence M. Taylor, Staff Service Analyst, Standards Compliance  59. Tracy Paepke, Intern Master of Social Work  60. Usha Sachdev, MD, Staff Psychiatrist  61. Wanda Wullschleger, Registered Nurse  62. Zakaria Boshra, MD, Chief Physician and Surgeon (QC)</p>
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		<p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Quality Council minutes</li> <li>2. FRC tracking log</li> <li>3. Listing of individuals who reached behavioral triggers each month during the review period</li> <li>4. WRPs of 27 individuals on behavioral high-risk lists</li> <li>5. WRPs of nine individuals tracking RM Committee recommendations</li> <li>6. WRPs of 17 individuals for medical high risks (reviewed by M. Jackman)</li> <li>7. Aggression data and analysis</li> <li>8. Mortality Review documents on individual HF;       <ul style="list-style-type: none"> <li>• Examination Protocol 10/1/10</li> <li>• Medical Death Summary 10/4/10</li> <li>• MIRC Minutes 10/7/10</li> <li>• Nursing Death Summary 10/4/10, amended 10/11/10</li> <li>• Independent External Medical Review 11/13/10</li> <li>• Internal Discipline Mortality Review -undated document</li> </ul> </li> <li>9. Mortality Review documents on individual IIG;       <ul style="list-style-type: none"> <li>• Medical Death Summary 12/20/10</li> <li>• Nursing Death Summary 12/27/10</li> <li>• MIRC Minutes 12/28/10</li> <li>• Discharge Summary 12/29/10</li> <li>• Internal Discipline Death Review - undated document</li> </ul> </li> <li>10. Mortality Review documents on individual OS;       <ul style="list-style-type: none"> <li>• Medical Death Summary 9/22/10</li> <li>• Nursing Death Summary 9/22/10</li> <li>• MIRC Minutes 9/28/10</li> <li>• Death/Discharge Summary 9/30/10</li> <li>• Independent External Medical Review 10/13/10</li> <li>• Internal Discipline Mortality Review - undated document</li> </ul> </li> <li>11. Sentinel Event Analysis of Walk-away and Self-Injury/Suicide Prevention Taskforce report to Quality Council 2/16/11.</li> <li>12. The Risk Management System's level I, II and III</li> </ol>
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		<p>response/recommendations for the following 9 individuals: CG, HL, JR, NK, PB, RC, RR, SM, and TC.</p> <ol style="list-style-type: none"> <li>13. MSH/LAC+USC Endoscopy Checklist form</li> <li>14. Draft #3 Flowchart for Stable Metro Swallower Patients 2/17/11</li> <li>15. List of Activated Triggers by Logged Date and Threshold Category 8/1/10 - 1/31/11</li> <li>16. ETRC meeting minutes 12/21/10</li> <li>17. PRC meeting minutes 12/9/10 and 12/13/10</li> <li>18. Analysis of Violence and Aggression at MSH by the Aggression Reduction Committee report to Quality Council 3/1/11</li> <li>19. MSH Risk Management Process</li> </ol> <p><u>Attended:</u> Quality Council meeting</p>
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<b>Compliance:</b> Substantial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current focus on the reduction of aggression.</p> <p><b>Findings:</b> See I.2.c for a short summary of some of the work done by the hospital analyzing violence/aggression data.</p> <p><b>Other findings:</b> Review of the lists of individuals who had met behavioral triggers during the reporting period found that five individuals present a particularly high risk to themselves or others because of the frequency and intensity of their</p>

aggressive acts. The tables below document the number of months in the six month review period (Aug.-Jan.) in which the individual reached the trigger. For example, HC reached the trigger for aggressive acts to self with major injury four of the six months under review.

Individual	SIB w/Major Injury	SIB 2 acts, 7 days	SIB 4 acts, 30 days
HC	4 months	5 months	5 months
PB	3 months	3 months	3 months
TC	3 months	3 months	3 months

Individual	Aggression to others w/Major Injury	Aggression to others 2 acts, 7 days	Aggression to others 4 acts, 30 days
CH	3 months	4 months	3 months
RR	2 months	3 months	4 months

**Current recommendation:**

Continue current focus on the reduction of aggression.

I.2.a.ii

establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and

**Current findings on previous recommendation:**

**Recommendation, September 2010**

Continue current practice.

**Findings:**

Review of key indicators related to aggression finds that the numbers of incidents of aggression resulting in injury to peers, staff and self has increased since the previous period. The number of individuals engaging in frequent aggression events (as defined in the KIs) decreased in the recent reporting period.

		<table border="1"> <thead> <tr> <th></th> <th>February-July 2010</th> <th>August 2010 - January 2011</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>36</td> <td>50</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>57</td> <td>70</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>15</td> <td>23</td> </tr> <tr> <td>Individuals with two or more aggressive acts in 7 days</td> <td>184</td> <td>167</td> </tr> <tr> <td>Individuals with four or more aggressive acts in 30 days</td> <td>125</td> <td>98</td> </tr> </tbody> </table> <p><b>Other findings:</b> The Quality Council minutes of January 17, 2011 include a review of the outcomes for individuals seen in the Facility Review Committee during the review period. This review included the type of risk that occasioned the FRC and the number of an individual's triggers of that risk type before the FRC and then after the FRC. Analysis of that data finds that the number of trigger events decreased <u>following</u> the FRC in 7 of 12 cases, increased in two cases, remained the same in two cases, and was not calculated in one case because the individual was discharged shortly after the FRC.</p> <p><b>Current recommendation:</b> Continue current practice, particularly in assessing outcomes.</p>		February-July 2010	August 2010 - January 2011	Peer-to-peer aggression resulting in major injury	36	50	Aggression to self resulting in major injury	57	70	Aggression to staff resulting in major injury	15	23	Individuals with two or more aggressive acts in 7 days	184	167	Individuals with four or more aggressive acts in 30 days	125	98
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I.2.a. iii	identification of systemic trends and patterns of high risk situations.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice of identify high-risk situations, implementing strategies to reduce the inherent risks and monitoring their efficacy.</p>																		

		<p><b>Findings:</b> The document <u>Analysis of Aggression and Violence at MSH</u>, which will soon be presented to the full Quality Council, is a comprehensive analysis of incident data that clearly identifies those population traits and situations/ circumstances that constitute high-risk situations. Please see I.1.d.iv, I.1.d.v, and I.1.d.vi for specific findings reported in that document.</p> <p><b>Current recommendation:</b> Continue current practice of data presentation and analysis.</p>
I.2.b	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p><b>Compliance:</b> Partial; substantial compliance is contingent on timely correction of the facility's poor response to two serious incidents described in I.2.b.iii and I.2.c and also addressed in F.3.g and H.b.8.</p>
I.2.b.i	<p>a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring during the maintenance phase.</p> <p><b>Findings:</b> The ETRC presented data on the triggers which occasioned reviews during this review period and the last. Findings include:</p> <ul style="list-style-type: none"> <li>• In both review periods, trigger 13.2 (individuals with two or more PRNs for behavioral/psychiatric reasons) had the highest counts. The count for the current period was less than for the previous one.</li> <li>• Individuals with two or more Stat meds in 24 hours and three or more Stat meds in seven days showed considerable decreases in this reporting period over the last.</li> <li>• Individuals with two or more aggressive acts to others in seven days had the second highest counts. This review period count was less than the previous period, however.</li> </ul>

		<ul style="list-style-type: none"> <li>• All triggers related to aggression to self showed higher counts this review period than in the previous period.</li> <li>• In this review period, peer-to-peer aggression resulting in major injury was higher, while the incidence of individuals with four or more aggressive acts to other in 30 days was lower than in the previous period.</li> </ul> <p><b>Other findings:</b> See also I.2.b.ii and I.2.b.iv for documentation of interventions by WRPTs to medical and behavioral triggers.</p> <p><b>Current recommendation:</b> Continue to monitor WRPs to ensure they acknowledge and address individuals' high-risk status.</p>
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring during the maintenance phase.</p> <p><b>Findings:</b> <u>Medical Key Indicators</u> The database lists presented to the CM team member for new diabetes diagnosis had dates that did not coincide with date of diagnosis in the records (which were also unclear, but seemed to suggest onset prior to dates on lists provided). In addition, when reviewing the high-risk lists for falls, choking, and decubitus, it was unclear when the individual met criteria for high risk. This may be due to the fact that the CM team member received the wrong lists, but based on what was provided, it was very difficult to determine accurate dates of onset of DM and entrance onto high-risk lists.</p> <p>As presented below, the Present Status of six WRPs reviewed did not</p>

reference the individual's medical high-risk status.

Individual	Issue	WRP documentation
MLC	12/21/10 met trigger 7.1 for fall with major injury	WRP dated 2/7/11 identified trigger in focus statement, but nothing about fall mentioned in WRP Present Status dated 1/1/11 that immediately followed the incident. Open focus 6.11 for fall risk with objective and intervention related to verbalizing fall prevention strategies. WRP stated that individual was referred for physical and occupational therapy evaluation but refused, though no referral was found in record.
EWVC	1/3/11 met trigger 7.1 for fall with major injury	WRP on 1/27 listed fall trigger, and open focus 6.30 for fall risk. He was referred for physical therapy evaluation in 10/10 and 1/19/11 for assessment and treatment of mobility-related fall risk but refused on both occasions.
SO	New diagnosis of diabetes *	The WRP dated 1/21/11 listed DM Type II or unspecified as an Axis III diagnosis. Focus 6.4 addresses DM with objective related to verbalizing DM signs and symptoms (however, the individual is unable to respond to questions), with RD education intervention. Dietitian assessment dated 11/18/10 showed continued recommendation for ADA diet; did not review glucose level.
JJF	New diagnosis of diabetes *	The WRP dated 1/20/11 listed DM Type II or unspecified as an Axis III diagnosis; focus 6.3 objectives and intervention in place for diabetes management by nurse, social worker, psychiatrist, and dietitian. Nutrition

			assessment dated 12/8/10 addressed diabetes factors and recommendations.
		SRM	New diagnosis of diabetes * The WRP dated 1/27/11 listed DM Type II or unspecified as Axis III diagnosis; focus 6.1 objective and intervention related to verbalizing DM symptoms to RN and RD in WRP. Nutrition assessment update on 12/23/10 addressed DM diagnosis.
		JP	Stage II Decubitus incident on 12/29/10 per key indicator report No mention of decubitus in WRPs following incident dated 1/26/11 and 2/24/11. Individual had a 24-hour support plan in place developed in October 2010 that had general positioning requirements, but plan was not reassessed or revised by POST following decubitus identification.
		TW	Stage III Decubitus incident upon admission on 10/08/10 Most recent WRP dated 12/30/10 lists decubitus stage IV that has changed to stage III though dates and status of healing/resolution are unclear in documentation. Individual referred for OT evaluation 10/15/10 but refused three times, and individual referred for PT evaluation that was completed 10/12/10, though individual refused PT treatment or indirect exercise program to improve mobility and thus reduce risk for pressure ulcers. Individual was issued a gel cushion for wheelchair from PT for pressure management following PT evaluation.
		FR	At high risk for falls High risk identified in the Present Status section of most recent WRP dated 2/15/11. Open focus 6.24 for fall risk with objective and intervention aimed at verbalizing fall

			prevention strategies (although she was quoted in focus statement as listing two things she does to prevent falls).
		PD	At high risk for falls High risk identified in the Present Status section of most recent WRP dated 2/24/11, though there is no open focus of treatment related to minimizing fall risk or preventing falls. Individual had physical therapy treatment in 2009 for gait instability, and was discharged per individual request and independence with home exercise program.
		KMS	At high risk for metabolic syndrome High risk identified in the Present Status of the WRP dated 1/21/11; open foci 6.1 for overweight, 6.6 for dyslipidemia. Nutrition assessment dated 12/28/10 provided recommendations to address contributing risk factors of elevated weight and lipids.
		CM	At high risk for metabolic syndrome High risk not identified in the Present Status of the most recent WRP dated 2/2/11. Nutrition assessment 12/22/10 addressed contributing risk factors of overweight and hypertension.
		CCK	At high risk for metabolic syndrome High risk not identified in Present Status of the most recent WRP dated 2/23/11, or previous WRP dated 1/25/11, though open foci 6.1 for overweight and 6.3 for dyslipidemia noted. Nutrition assessment completed on 10/27/10 addressed obesity and dyslipidemia.
		JJW	At high risk for impaired skin integrity High risk not identified in the Present Status of the most recent WRP dated 9/14/10. Individual receiving OT services for contracture management but no

			documentation of treatment related to risk for impaired skin integrity due to limited mobility and cognitive decline noted.
		JRL	At high risk for choking Speech therapy evaluation completed 2/7/11 (5 days after admission; referral written 2/2/11) due to history of aspiration pneumonia and subsequent hospitalizations during 2010. High risk identified in the Present Status of the most recent WRP dated 2/15/11, with 6.5 objective and intervention in place to address risk. In addition to MSH interventions, the speech therapist provided training to conservator in regards to foods that are allowed and not allowed with current diet texture and liquid consistency. 24-hour support plan has not been developed or implemented, though appears to be clinically indicated for both choking risk and positioning issues.
		RAJ	At high risk for choking High risk identified in the Present Status of the most recent WRP dated 2/15/11, and 6.7 objective and intervention in place to address risk via modified diet. The WRP indicated that he has had no choking incidents since admission to MSH in 4/17/08, though high-risk list states that he has a history of choking incident (perhaps prior to admission). No evidence of SLP referral or assessment was found during the review period, though it may not have been clinically indicated, as he has been stable on a modified diet.
		LW	At high risk for choking High risk not identified in the Present Status of the most recent WRP dated 2/23/11, but

				<p>identified in open focus 6.7 with objective and intervention in place to address risk via modified diet. SLP assessment was performed 1/28/11 and recommended changing diet to puree with thin liquids with implementation of safe swallowing strategies; integration noted in 6.7.</p>
		JLC	At high risk for choking	<p>High-risk list states that she has a history of choking incident (perhaps prior to admission), but no mention of high risk, previous incident, or open focus to address risk in most recent WRP.</p>
		<p><b>Other findings:</b>  The QC minutes of 12/16/10 state that the QC has a work group assigned to address choking composed of Nutrition Services, POST teams, Nursing and Medical. A report of this workgroup is due to the QC on 2/28/11.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Include the report of the work group on choking and the discussion of the report in the QC minutes as soon as it is available.</li> <li>2. See also recommendation in I.2.b.iv.</li> </ol>		
I.2.b. iii	<p>formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b>  Continue current practice.</p> <p><b>Findings:</b>  In nearly all cases, the WRPs for the sampled individuals on behavioral high-risk lists addressed the risk in Present Status and with treatment interventions and objectives.</p>		

High-Risk List-- Aggression to Self

Individual	WRP	Included in Risk Factors	Focus
AR	10/14	Yes	3.1
HH	2/15/11	Yes	3.1
JC	2/14/11	Yes	3.1
MC	2/7/11	No	3.1
MD	3/2/11	Yes	Not addressed
PB	2/7/11	Yes	1.4 and 3.1
SP	1/25/11	Yes	3.1

High-Risk List-- Suicide

Individual	WRP	Included in Risk Factors	Focus
IB	3/8/11	Yes	3.1
JL	3/7/11	Yes	1.1
KS	2/3/11	Yes	1.1
SG	10/13/10	Yes	1.1

High-Risk List-- Victimization

Individual	WRP	Included in Risk Factors	Focus
AL	7/12	Yes	3.1
BH	3/3/11	No	Not addressed
CM	3/7/11	Yes	2.1
GB	2/1/11	Yes	2.1
HH	2/15/11	Yes	2.1
JF	2/17/11	Yes	3.1
JL	3/7/11	Yes	2.1

KE	2/8/11	Yes	2.1
LD	2/15	Yes	3.1
TC	3/3/11	Yes	3.1

High-Risk List--Aggression to Others

Individual	WRP	Included in Risk Factors	Focus
BJ	3/1/11	Yes	2.1 and 3.1
JR	2/24/11	Yes	3.1
ML	8/25/10	Yes	3.1
RS	2/28/11	Yes	3.1
SG	10/13/10	Yes	1.1
VA	2/14/11	Yes	3.2

**Other findings:**

In contrast to the largely positive findings reported above is the Risk Management handling of two incidents (2/17 and 2/28/11) of entrapment in bedside rails involving JL. The MRMC reviewed JL on 2/23 and, as documented in the minutes, did not identify the specific issues that contributed to the incident. It made recommendations that were to be in place in 30 days, only some of which were directly related to the prevention of a recurrence and some of which offered no guidance to staff for specific actions. Recommendations included: Ensure JL's safety in bed, continue 1:1 monitoring and reassess as clinically indicated, explore causes of agitation, get definitive diagnosis of Huntington's Disease by DNA testing, use PRN medications to control anxiety and agitation, evaluate the benefits of a wheelchair and follow up with obtaining one if indicated.

A second set of recommendations was presented to the ED and other senior staff on 3/4/11 and included actions to be implemented immediately or in the near future: change to a different type of bed, change to a room nearer the nurses' station, place a removable device in the gap between the half

		<p>rails, put floor mats in place, replace current bedrail padding with a thicker one, place bolsters for positioning in the bed and in the geri chair, and place an alarm on the edge of the bed and on the geri chair. CM team member observation found that JL remained bed-bound, had not been moved to a different room, no alarms were present, and documentation indicated the geri chair and torso support and bed bolsters were ordered from the supplier on 3/1 and 3/4/11.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that reviews of particularly serious incidents and near misses include the identification of contributing factors and match recommendations to these factors.</li> <li>2. Ensure that recommendations are actionable and provide sufficient guidance so that accountability for implementation can be monitored.</li> </ol>								
I.2.b. iv	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> The review of 19 ETRC recommendations made on behalf of eight individuals found that subsequent WRPs addressed 10 of the recommendations as shown:</p> <table border="1" data-bbox="955 1117 1875 1409"> <thead> <tr> <th data-bbox="955 1117 1129 1230">Individual Key Indicator</th> <th data-bbox="1129 1117 1304 1230">RM Committee date</th> <th data-bbox="1304 1117 1570 1230">Recommendations</th> <th data-bbox="1570 1117 1875 1230">WRP documented response</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 1230 1129 1409">TC Agg to self</td> <td data-bbox="1129 1230 1304 1409">ETRC 11/2 and 11/30/10</td> <td data-bbox="1304 1230 1570 1409">Assess cognitive level. Review med regimen.</td> <td data-bbox="1570 1230 1875 1409">WRP 12/2 cites both recs. WRP 1/3 cites both recs again. WRP 2/3 does not specifically address</td> </tr> </tbody> </table>	Individual Key Indicator	RM Committee date	Recommendations	WRP documented response	TC Agg to self	ETRC 11/2 and 11/30/10	Assess cognitive level. Review med regimen.	WRP 12/2 cites both recs. WRP 1/3 cites both recs again. WRP 2/3 does not specifically address
Individual Key Indicator	RM Committee date	Recommendations	WRP documented response							
TC Agg to self	ETRC 11/2 and 11/30/10	Assess cognitive level. Review med regimen.	WRP 12/2 cites both recs. WRP 1/3 cites both recs again. WRP 2/3 does not specifically address							

				the two recs, but notes TC has BGs and DBT training to address SIB.	
		HH Agg to self	ETRC 11/25/10	Expand BGs. Consider conducting Beck Depression Inventory	WRP 2/15/11 provides no f/u information.
		PB Agg to self	ETRC 12/21/10	Evaluate, revise and implement BGs.	WRP 2/24 states a third BG was created on 12/16 for DTS. BGs were reviewed and adjusted and will be implemented following staff training on 12/24.
		AR Agg to self	ETRC 9/28/10	Refer for neuro-psych assessment. Refer for sleep apnea study. Expedite BGs.	WRP 1/13/11 states met with neuro-psychologist on 10/8. Testing not likely to produce additional information. No f/u on sleep apnea study. Referred to PBS on 9/23 due to severity of behavior.
		MD Agg to self	ETRC 7/20/10	Get EKG. Get medication level. Consider more sedating medication.	WRP 9/2/10 provides no documentation of f/u for EKG or medication level.
		SP	ETRC	Consider replacing	WRP 1/25/11 notes

		Agg to self	11/13 and 12/7	Clonidine with Minipress. Increase lithium and Cymbalta after consultation with the cardiologist.	the replacement was completed. States individual seen by cardiologist with recommendation to continue lithium and monitor EKG.
		ML Aggression	ETRC 8/10/10	Incorporate PBS plan interventions into Focus 2 for social skills and into Focus 3 for dangerousness	WRP 8/25/20 indicates PBS interventions incorporated into Focus 3.
		SG Aggression	ETRC 9/21/10	Implement BGs w/ focus on attention seeking. Add Borderline Personality Disorder to diagnosis. Complete cognitive screening. Consider tx with SSRI.	WRP 10/13/10 states BG referral was done on 7/28/20. In the process of being developed. Borderline Personality Disorder listed as proposed Axis II diagnosis. Will attempt further cognitive testing within 30 days. Medications include trazodone.
		<p><b>Current recommendation:</b>  Consider reissuing the directive to WRPs that provides guidance on where in the WRP to list RM Committee recommendations and where to identify the actions taken in response to the recommendations.</p>			

I.2.b.v	<p>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010</b> Continue current practice and monitoring during the maintenance phase.</p> <p><b>Findings:</b> In an effort to move analysis beyond a focus on the process of identifying individuals and ensuring they are seen by RM committees as appropriate, MSH turned attention to outcomes. The hospital graphed the relevant behaviors before and following the FRC review for nine individuals during the reporting period. The results for six individuals include:</p> <ul style="list-style-type: none"> <li>• A steep decline in aggression for JR following the 8/5/10 FRC deliberations that continued through January 2011.</li> <li>• Low number of incidents for CO in August and September (FRC 8/19/10) with a significant spike in incidents in October after which a second FRC was convened. November and December saw no incidents, and CO was discharged in December.</li> <li>• The FRC reviewed the incidents of aggression to self and to others by HC on 9/6/10. Self-aggression spiked in October and then declined through January. Aggression to others remained at comparatively low frequency through the review period, as did suicide attempts.</li> <li>• Following the FRC on 10/7/10, MG had no incidents of suicide threats, suicide attempts or self-aggression through December. In January MG had two incidents of suicide threats and one incident of self-aggression.</li> <li>• During the review period, NK's self-aggression showed two spikes in October (19 incidents) and in January (23 incidents). In response, she was reviewed in FRC in early November and on January 20, 2011.</li> <li>• Episodes of aggression to others showed a pattern during this review period that is similar to the one from the last review period.</li> <li>• In response to two suicide attempts in October and three incidents of aggression to self in November, FR was reviewed at the FRC on 12/2/10. No suicide attempts were recorded after October through February and</li> </ul>
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		<p>self-aggression incidents declined in December to two and in January to one, with none recorded for February.</p> <p><b>Recommendation 2, September 2010</b> Address the need to ensure that full evaluations follow when screenings indicate.</p> <p><b>Findings:</b> As documented in I.2.b.ii, there were no instances in the medical triggers sampled of the failure to provide a full evaluation when screenings indicated the need. There was, however, one instance in which no referral was found for PT or OT for fall risk and one instance of no 24-hour support plan for an individual at high risk for choking.</p> <p><b>Other findings:</b> This monitor and his experts interviewed members of the WRPTs who provided care to nine individuals (CG, HL, JR, NK, PB, RC, RR, SM and TC) who met a variety of high-risk triggers/thresholds including aggression to self, peers and/or staff, use of PRN medications and use of restrictive interventions (seclusion/restraint). These interviews included reviews of the charts of these individuals. The main purpose of this review was to assess implementation of the current DMH Risk Management policy/procedure. Based on these reviews and interviews, this monitor found evidence of positive clinical outcomes in most individuals and adequate implementation of the current risk management system, including the following:</p> <ol style="list-style-type: none"> <li>1. Triggers for review were prioritized in a manner that increased the efficiency of the system to address high-risk individuals;</li> <li>2. The reviews by the treating psychiatrists of individuals who reached triggers/thresholds were, in general, timely and adequate;</li> <li>3. There was general evidence of meaningful, clinically relevant reviews and recommendations by the Program Review Committee (PRC), the Enhanced</li> </ol>
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		<p>Trigger Review Committee and the Facility Review Committee (FRC); and</p> <p>4. The behavioral interventions were generally timely and properly designed and adequately implemented.</p> <p>The QC minutes during the review period cite attention to MSH's Risk Management system on several occasions:</p> <ol style="list-style-type: none"> <li>1. The 8/12/10 minutes indicate that the Medical Director, Acting Clinical Administrator and Acting Nurse Administrator agreed to attend PRC meetings to offer support and constructive feedback to teams. The minutes further noted the need for ETRC, PRC and MRMC recommendations to be included in the WRP. The 8/28/10 minutes indicate that the staff leaders cited above had been attending PRC meetings.</li> <li>2. The 9/23/10 minutes cite the work of several staff in leadership positions in identifying areas in need of improvement, such as including risk status in the WRP. They also cite the need to encourage PRCs to do a more clinical review before submitting to ETRC.</li> <li>3. The 10/14/10 minutes cite work continuing with WRPTs and review for high-risk cases needing outside consultation. The Chief of Psychiatry provided training to PRC teams, which was deemed very helpful.</li> </ol> <p><b>Current recommendations:</b> Continue current practice of monitoring the operation of and the outcomes achieved through the Risk Management Committees.</p>
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue the work necessary to bring the facility into substantial compliance with the EP and maintain substantial compliance-level performance.</p> <p><b>Findings:</b> The Quality Council minutes of December 16 discuss changes in the</p>

		<p>operation of the Council. Specifically, the ED advised members that work groups must report on their due date and not ask for discussion to be deferred. She stated that critical attention needs to be given to these reports. The ED also led a discussion on the necessity of accuracy in data, analysis, identification of trends and patterns, and the development of a corrective action plan with specific target dates for implementation.</p> <p><b>Other findings:</b></p> <p>This monitor interviewed members of the Quality Council and reviewed a report from the Aggression Reduction Committee that was submitted to the Council on January 24, 2011 as well as minutes and attachments of the Council's meetings during this review period. During the interview with members of the council, the Treatment Enhancement Coordinator and the Medical Director made a joint presentation of a recent report from the Aggression Reduction Committee (March 1, 2011) that was yet to be submitted to the Quality Council.</p> <p>The purpose of the interviews and reviews was to assess the facility's quality management/performance improvement function focusing on the oversight function that was provided by the Council. This review prioritized the facility's analysis and management of aggression. This following is a summary of the monitor's findings:</p> <ol style="list-style-type: none"><li>1. The Aggression Reduction Committee report of January 24, 2011 analyzed Key Indicator and other data from March 2010 to January 2011; portions of this analysis are presented in I.1.d.iv. This report contained adequate review and analysis of trends and patterns of aggression at MSH and an outline of a variety of data-based and other systemic corrective actions that had been implemented and other actions that were in process or being planned. The analysis showed that although the overall trend of aggression to self and others have increased slightly, the trend of repeated aggression was decreasing. The corrective actions included the following:</li></ol>
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		<ul style="list-style-type: none"><li>a. The Risk Management SO, including three levels of reviews, had been fully implemented and the facility presented data showing that in general, each level of review correlated with a decline in aggressive acts and triggering behavior after an individual's case had been reviewed at each of these levels.</li><li>b. Administrative staff held meetings with unit staff to address a delay in the implementation of restrictive interventions when these interventions were clinically indicated to ensure safety. The meetings addressed a misperception by some staff that the use of restrictive interventions was prohibited regardless of circumstances. The discussion included education about the need for appropriately employing crisis intervention strategies when an individual's behavior is escalating.</li><li>c. Recommendation was made to limit the quantity and variety of allowables to address a finding of specific assaults related to contraband issues.</li><li>d. Efforts were underway to collaborate with the District Attorney to charge and arrest individuals who lack primary Axis I diagnosis based on data showing that certain assaults on staff and/or peers were driven by psychopathy and not by Axis I psychiatric disorders.</li><li>e. Biological treatment initiatives included plans to finalize an Administrative Directive to make electroconvulsive therapy available on campus and establishment of a task force to review an evidence-based psychopharmacological algorithm to address increased aggression on acute units (410, 413 and 405 followed by 412 and 409).</li><li>f. Plans were made to explore the feasibility of an intensive treatment unit for highest-risk individuals.</li><li>g. The facility instituted a Supplemental Activities Program that provided an average of 17 hours per week in the most recent period of activities in the evenings, weekends and holidays as well as school activities during the day.</li><li>h. In the fall of 2010, MSH implemented a Cognitive Therapy Center</li></ul>
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		<p>(CTC) separate from the regular PSR Mall to address data showing correlation between assaults and cognitive impairments. This has resulted in less contact with aggressive peers and related victimization. A cognitive mentoring process was also implemented to provide individuals with opportunity to assist others.</p> <ol style="list-style-type: none"> <li>i. Narrative Restructuring Therapy was provided to improve adherence to treatment.</li> <li>j. Staff trainings were provided including Mindfulness-Based Approaches to Building Therapeutic Alliance and Therapeutic Milieu Training on proactive methods of enhancing safety when confronting behavioral problems.</li> <li>k. Staff trainings were planned including Motivational Interviewing.</li> <li>l. The debriefing process/form following the use of seclusion/restraint was revised to include participation by the individual and the WRPT members.</li> <li>m. A variety of environmental measures was recommended including establishment of grounds presence team, a fence alarm system for secure areas, a central communication control system and a closed circuit television system, base/receiver radio, and additional modular unit(s) in the forensic compound.</li> <li>n. In July, HPD initiated a pilot program of performing rounds on units identified as having a high incidence of aggression. Presently HPD were making rounds on all units.</li> <li>o. Proposal was made for enhance unit staffing.</li> </ol> <ol style="list-style-type: none"> <li>2. On March 1, 2011, the Treatment Enhancement Coordinator and the Medical Director completed a detailed second-order analysis of factors contributing to aggression patterns and trends. This analysis provided the basis for further data-based corrective actions. This report had yet to be reviewed and approved by the facility's Quality Council.</li> <li>3. The QC minutes during the review period document the discussion of various forms of aggression occurring at the hospital and recommendations to address these issues. One such topic is Safety and Security on the Units for Individuals and Staff. Activities included:</li> </ol>
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		<ul style="list-style-type: none"> <li>a. The October 28 and December 16 meeting minutes cite the need for discussion (in an open at-large forum and on units) with staff regarding personal safety, for review of the role of hospital police/security and for a re-evaluation of the policy for visitors.</li> <li>b. The 8/26/10 minutes state that the QC will review options for creating a unit for individuals at risk of victimization, possibly using Unit 420.</li> <li>c. The QC held brain-storming sessions on Nov 1 and 2 on hospital security which identified equipment needs, areas for improvement in scheduling appointments, use of escorts, count procedures, and moving certain clinics to behind the compound.</li> <li>d. The Aggression Reduction Committee reviewed data for a pilot project to increase HPD presence during times of increased violence and aggression.</li> <li>e. An MSH physician provided statewide training on Aggression and Violence in Mental Health Settings on 1/21/11.</li> <li>f. The minutes of the 1/27/11 meeting note the presentation of Key Indicator data and the patterns and trends reflected in that data.</li> <li>g. Aggression data showed that the LPS population continues to show the highest rate of aggression, especially aggression to self and that 20 individuals account for approximately 45% of the aggression triggers at MSH.</li> <li>h. A second topic related to aggression toward self. QC activities included: <ul style="list-style-type: none"> <li>i) The 8/26/10 meeting minutes discuss self-injury in Program II and state that the Unity Plan provided structure on the unit and an environment for increased positive interaction between staff and individuals.</li> <li>ii) The 9/23/10 minutes cite the ongoing review of the Unit 416 milieu plan and a proposal to expand the program to Units 410 and 412. The 10/12 minutes state that Unit 410 staff members have been trained.</li> </ul> </li> </ul>
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		<p>While it is possible to trace issues through various stages of discussion, to formal studies, to recommendations, to implementation, to evaluation of effectiveness, this results in the finding that some issues are lost. For example, there was no discussion of the IRC issue brought to the QC regarding staff's failure to report A/N/E at the 10/14 meeting as planned. Discussion was deferred to the next meeting. At the 10/28 meeting this discussion was again deferred. The issue was discussed at the 12/23/10 meeting with an acknowledgement that performance improvement in this area is essential and must be addressed systematically to eliminate the problem. It was determined "there is a need to develop components for training staff." January minutes do not address this issue. In the spirit of the December 16 minutes, it seems advisable to develop a tracking system that presents the status of all recommendations presented for review and is distributed and/or discussed at each QC meeting.</p> <p>This monitor reviewed the facility's Mortality Review documents pertaining to all unexpected mortalities (IIG, HF and OS) that occurred during this review period. One of the monitor's experts gave input into the review of HF. The monitor also interviewed the Medical Director and the Executive Director in this regard. There was general evidence of adequate reviews of the cases of IIG and OS, including recommendations for systemic corrective actions as appropriate. However, from a performance improvement standpoint, the mortality review of the choking death of HF was inadequate. It was noted that the facility's Executive Director did not attend this review (or any of the other reviews of unexpected mortalities during the review period). In personal interview, the Director did not present evidence of being adequately informed of the systemic/interdisciplinary issues that were or should have been identified this case. This is a significant process deficiency, which deprived the facility of necessary administrative oversight in the development, implementation and coordination of interdisciplinary corrective actions related to the risk of choking in the facility. Although some corrective actions were developed by the facility, there was evidence of lack of attention to other necessary</p>
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		<p>requirements in the process of reviewing a choking death of an individual and of systemic and timely corrective actions to decrease the risk to other individuals at the facility.</p> <p>The above mentioned deficiency in administrative oversight was also evident in the facility's failure to conduct an adequate review and analysis of factors that contributed to two successive events that involved one individual (JRL) and that had significant potential for serious harm to this individual (see H.b.8, F.3.g and I.2.b.iii). In this case, the facility did not develop or implement needed clinical and systemic data-based corrective actions to minimize the risk of harm for this individual.</p> <p><b>Compliance:</b> Partial; substantial compliance is contingent on adequate and timely implementation of above-mentioned corrective measures recommended by the Aggression Reduction Committee and improvement of senior administrative oversight of quality management including sentinel events and mortality reviews.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Ensure adequate implementation of corrective actions that were initiated or recommended by the facility's Aggression Reduction Committee and provide periodic updates to this monitor regarding the status of implementation of each action.</li><li>2. Ensure adequate administrative oversight of the facility's Quality Management system, including sentinel events and mortality reviews.</li><li>3. Proceed with plans to improve the accountability of workgroups in reporting in a timely manner to the QC with identification of areas for improvement and recommendations for corrective actions.</li><li>4. Consider developing a task tracking system for the QC similar to the one used by the IRC.</li></ol>
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3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. K. Moran, Hospital Administrative Resident</li> <li>2. L. Conkleton, Chief of Plant Operations</li> <li>3. Several individuals (casual conversations) on the units toured</li> <li>4. Several staff members on the units toured</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. WRPs of 14 individuals for treatment focus for incontinence</li> <li>2. Clinical records of nine individuals for IDNs related to sexual incidents</li> </ol> <p><u>Toured:</u> Units 409, 412, 414 and 416</p>
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, September 2010</b> Reposition the shower chair in a bathroom on Unit 407 and ensure that the shower regulator valve in the bathroom will not support a ligature.</p> <p><b>Findings:</b> The shower regulator valves have been replaced with push-button systems and snubbed shower heads.</p> <p><b>Recommendation 2, September 2010</b> Provide guidance to the units as to ensure that all staff (including those floating from another unit) will be able to access the cut-down instrument in an emergency by identifying one place where it will be kept unencumbered on all units.</p> <p><b>Findings:</b></p>

		<p>Staff were able to show this CM team member the cut-down instrument on each of the units toured. They were stored in the sharps drawer in the nurses' station on each unit.</p> <p><b>Recommendation 3, September 2010</b> In view of the observation of an unclothed woman on Unit 412 and the sightings of two unclothed individuals made during program management rounds, the facility needs to clarify its expectations regarding unclothed individuals in common areas.</p> <p><b>Findings:</b> The facility reported that the AD Individual Dress Code states, "Individuals must be dressed by breakfast and remain dressed until bedtime, unless a physician has ordered bed rest for the individual." This policy was redistributed to employees.</p> <p><b>Other findings:</b> Bathrooms on units visited were not free of suicide hazard as the partitions were tall and stall doors shorter. The under-the-sink plumbing was not covered. On Unit 412 the vent above a raised bathtub appeared to be accessible and the mesh is large enough that a ligature can be passed through. The move of the Program II units to the 100 building is still being planned.</p> <p>Each unit toured had working flashlights for making nighttime rounds. The staff members escorting during the unit tours pointed out weighted chairs in the day halls that cannot be picked up and used as weapon. MSH plans to phase-in weighted chairs in the dining room as well.</p> <p>The counts of individuals on Units 412 and 416 were appropriately completed, i.e., were completed on time and not in advance or late.</p>
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		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Investigate and address as necessary the vent on Unit 412 above the raised bathtub.</p>
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation , September 2010</b> Continue current practice.</p> <p><b>Findings:</b> During the tour, the medication room, the nurses' station and the west wing of Unit 414 were very warm. Staff reported this is not an uncommon occurrence.</p> <p><b>Other findings:</b> The hospital reported that during the review period, there were 178 temperature-related work order calls—all of which were addressed and the situation corrected.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Discuss with Unit 414 staff whether the warm temperature in parts of the unit is a frequent issue.</p>
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice.</p>

**Findings:**

The WRPs of each of the 14 individuals selected from the listing of individuals with the problem of incontinence addressed the medical issue. This finding is consistent with MSH's review, which found that among its 100% sample of individuals with incontinence, 97% of the WRPs addressed the problem in Focus 6. The facility also found that all of the individuals were clean and in all instances nursing staff was able to describe how they assist the individual with the problem.

Individual	WRP	Tx Focus
AD	2/24/11	6.9
AG	10/19/10	6.2
BJ	3/1/11	6.13
DM	11/15/10	6.4
EA	2/10/11	6.11, 6.17
FR	2/7/11	6.8
JG	3/8/11	6.5
KG	2/10/11	6.4
LB	3/3/11	6.12
MB	2/24/11	6.12
MG	2/10/11	6.10
SM	2/28/11	6.7
TC	3/3/11	6.8
VF	2/24/11	6.20

**Compliance:**

Substantial.

**Current recommendation:**

Continue current practice.

I.3.d	<p>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, September 2010</b> Continue to monitor compliance with this portion of the EP.</p> <p><b>Findings:</b> A review of staff's response to six sexual assault incidents, as documented in the IDNs, yielded variable results. In all instances, the physical needs of the individuals were met. In some instances, individuals were provided education and were counseled or advised that staff were available to them, but not in all instances. In several instances there were no IDNs describing staff's response to the incident.</p> <ul style="list-style-type: none"> <li>• The clinical record for SG, the victim in what she described as consensual sexual contact with a male in the female bathroom, documented the following responses by staff: Instructed not to change or wash and was sent to Rape Clinic. At MSH, labs were done and Plan B contraceptive provided. She was encouraged to verbalize feelings with staff, if needed. "Has not voiced any psychological concern re: alleged rape." It is not clear why the incident was treated as a sexual assault.</li> <li>• The male participant in the above incident also characterized the activity as consensual. He was educated on "sexually transmitted infection precaution/prevention."</li> <li>• SD, the alleged victim of sexual assault (no penetration) on 10/25/10, was cited as not wanting to talk further about the incident, but was encouraged to verbalize her feelings. She reported feeling unsafe on the unit due to male peers. Staff suggested she be kept on observational status for the next few days and that she report any incidents immediately as well as ask for PRN medication for sleep as needed.</li> <li>• There were no IDNs mentioning the incident in the records of the individuals named as the male aggressors (CM and CH) in the above incident.</li> </ul>
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		<ul style="list-style-type: none"> <li>• SD also alleged that on 10/13 she was raped by a male peer. She was sent to the USC Rape Clinic. MSH reported they educated SD on the importance of abstinence and advised her to notify staff immediately if approached for sexual favors. SD took Plan B contraceptive and offered "no complaints of pain or discomfort."</li> <li>• There is no mention of counseling or education in the IDNs of the alleged aggressor (AG) in a male-to-male sexual incident. It is not clear whether the activity was consensual or not. The victim's description is one of an assault. The victim was transferred to a co-ed unit upon his request the next day.</li> <li>• SP left a message with Patients Rights claiming a new peer in his dorm was threatening him and asking for sexual favors daily. He requested a dorm change, which was immediately provided. There is no further mention of staff's response to the allegation.</li> <li>• Four days after the event, MK reported that in the bathroom at his group site, he was punched in the mouth, fondled and raped. He was taken to USC on the date of the report. Diagnostic procedures were carried out in response to complaints of pain. He was returned to MSH and an antibiotic was prescribed for a UTI. A note by the unit psychologist states that MK offered some details of the rape, but did not identify the perpetrator. "He did not say he was suffering physically or psychologically due to the alleged rape."</li> <li>• Following the report that TM was engaged in oral sex on the grounds with two peers, staff notes state "attempted to talk to [TM] about when she was on grounds . . . and she was doing oral sex. She stated, 'leave me alone, nothing happened.' Individual was educated on practicing abstinence/safe sex. Educated on STD and ways to contact them. Individual stated, 'I already know.'"</li> </ul> <p>There were approximately 39 sexual incidents during the review period. Facility audit data was provided on 39 audits and found that education was provided in 38 cases and psychological care was provided in counseling was provided in 33 cases. These findings are more positive than those presented</p>
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		<p>above.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this portion of the EP.</p>															
I.3.e	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, September 2010</b> Continue current practice and monitoring during the maintenance phase.</p> <p><b>Findings:</b> The current data below was provided by the facility and the earlier data is also facility-reported data provided during an earlier visit.</p> <table border="1" data-bbox="955 821 1824 1015"> <thead> <tr> <th>Course</th> <th>Nov 08-April 09</th> <th>Aug 10-Jan 11</th> </tr> </thead> <tbody> <tr> <td>PMAB/TSI</td> <td>94%</td> <td>89%</td> </tr> <tr> <td>CPR</td> <td>88%</td> <td>92%</td> </tr> <tr> <td>First Aid</td> <td>94%</td> <td>76%</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>79%</td> <td>97%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial—as related to equipping non-clinical staff to assist in providing Mall services.</p> <p><b>Current recommendation:</b></p> <ol style="list-style-type: none"> <li>1. Address the decline in the percentage of staff who have completed First Aid training.</li> <li>2. Continue monitoring during the maintenance phase.</li> </ol>	Course	Nov 08-April 09	Aug 10-Jan 11	PMAB/TSI	94%	89%	CPR	88%	92%	First Aid	94%	76%	Recovery (Chapter 1)	79%	97%
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<b>J. First Amendment and Due Process</b>		
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	As of the tour conducted in September 2010, MSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.