

**REPORT 9**

**METROPOLITAN STATE HOSPITAL**

**August 30 - September 3, 2010**

**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.

## Table of Contents

<b>Acronyms used in Court Monitor reports:</b> .....	<b>iv</b>
<b>Introduction</b> .....	<b>xi</b>
<b>C. Integrated Therapeutic and Rehabilitation Services Planning</b> .....	<b>21</b>
1. Interdisciplinary Teams .....	22
2. Integrated Therapeutic and Rehabilitation Service Planning (WRP) .....	35
<b>D. Integrated Assessments</b> .....	<b>103</b>
1. Psychiatric Assessments and Diagnoses .....	105
2. Psychological Assessments .....	126
3. Nursing Assessments .....	130
4. Rehabilitation Therapy Assessments .....	141
5. Nutrition Assessments .....	161
6. Social History Assessments .....	178
7. Court Assessments .....	184
<b>E. Discharge Planning and Community Integration</b> .....	<b>187</b>
<b>F. Specific Therapeutic and Rehabilitation Services</b> .....	<b>201</b>
1. Psychiatric Services .....	203
2. Psychological Services .....	233
3. Nursing Services .....	259
4. Rehabilitation Therapy Services .....	277
5. Nutrition Services .....	287
6. Pharmacy Services .....	294
7. General Medical Services .....	297

8. Infection Control .....	322
9. Dental Services .....	340
<b>G. Documentation .....</b>	<b>352</b>
<b>H. Restraints, Seclusion, and PRN and Stat Medication .....</b>	<b>353</b>
<b>I. Protection from Harm .....</b>	<b>366</b>
1. Incident Management .....	368
2. Performance Improvement .....	399
3. Environmental Conditions .....	414
<b>J. First Amendment and Due Process .....</b>	<b>424</b>

**Acronyms used in Court Monitor reports:**

AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
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
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
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
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)
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
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms

EPT	Executive Policy Team
ETRC	Enhanced Trigger Review Committee
FMLA	Family and Medical Leave Act
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
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HAU	Hospital Annual Update (training)
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
HTN	Hypertension
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?
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 Staphylococcus aureus
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
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NEC	Nurse Executive Council
NEO	New Employee Orientation
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
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)
R&R	Rule(s) and Regulation(s)
RBANS	Repeatable Battery for the Assessment of Neuropsychological Status
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
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
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
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRN	Supervising Registered Nurse
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis

TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
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 August 30 to September 3, 2010 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 compliance in the future. 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 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, 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. The data that suggest clustering of reported medication variances in certain months and the 80% increase in grade III obesity over the review period should elicit curious review.

## 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.

c. In general, the facility has maintained progress in self-monitoring processes. However, in a few critical areas (e.g. substance use services), the facility's initial data set was internally inconsistent.

d. The facility's Key Indicator data did not include an unexpected mortality. It is unacceptable at this stage that obvious errors are made regarding a straightforward indicator that addresses a limited number of major events.

e. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals, including key indicator data, should be reviewed quarterly by the State with its Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

f. The facility's outcome data regarding medical services indicated that MSH has, in general, maintained progress in the delivery of medical services.

- g. MSH presented outcome data regarding mental health services as requested by this monitor. This data is addressed in cell F.1.i.
- h. All facilities are encouraged to ensure that the practice of self-assessment reliably informs performance improvement in the systems of clinical care.

### 3. Implementation of the EP

- a. The facility's progress is summarized in each corresponding section in the body of the report.
- b. MSH has many practitioners and clinical leaders who deserve accolades for their continued professional growth and for their ongoing dedication and commitment to the care of the individuals and to the facility's ultimate success in this process.
- c. In general, MSH has maintained progress in disciplinary services during this review period. However, the facility's progress was less than adequate in a number of critical areas that require integration of services at the senior administrative level. For example, in at least one major event, it was evident to this monitor that MSH did not provide appropriate, adequate and timely administrative oversight in an event that had potentially serious implications regarding the care and safety of other individuals at the facility.
- d. DMH is encouraged to continue and finalize, in a timely manner, current efforts to streamline some of the templates for documentation of WRPs and disciplinary assessments and reassessments with input from its clinical staff. Initiatives are currently underway to achieve this objective. As mentioned previously, the main purpose is to ensure an appropriate balance between time allocated for direct care services and time allocated for documentation and monitoring of the implementation of these services. Leadership and coordination by the facilities' Medical Directors are critical in this endeavor. This monitor will accommodate appropriate modifications in the facilities' self-assessment data that may be necessary as a result of this process and will modify, as needed, the process of on-site chart reviews to corresponding to these modifications.
- e. Psychiatrists, as attending physicians, should have the option of running groups consisting only of individuals under their direct care. This option is necessary to ensure adequate clinical attention to the needs of individuals for which the attending physicians have responsibility as direct care providers.
- f. DMH should continue its efforts to standardize across all hospitals the Administrative Directives that guide clinical services.
- g. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. MSH has continued its progress towards this goal, as specified in relevant sections in this report. It is worth mentioning that MSH has made further progress in assessing the cognitive status of its individuals and providing an adequate number and range of group interventions to address the needs of these individuals. At this juncture, it appears that all four facilities have achieved a system of assessment and care of 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 made progress to ensure that the information is consistently filed in the charts.
- i. Those facilities that have 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.

4. Staffing

The table below shows the staffing pattern at MSH as of July 31, 2010:

<b>State Hospital Vacancy Totals as of 7/31/10</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	0.00%
Licensed Vocational Nurse	38.00	33.00	5.00	13.16%
Psych. Tech., Psych. Tech. Asst., PLPT, PTT*	286.93	286.00	0.93	0.32%
Sr. Psychiatric Technician	41.00	33.00	8.00	19.51%
Registered Nurse*	201.79	157.00	44.79	22.20%
Supervising Registered Nurse	9.00	6.00	3.00	33.33%
Unit Supervisor	17.00	13.00	4.00	23.53%
Nurse Practitioner	1.00	1.00	0.00	0.00%
<b>LOC Professionals</b>				
Physician & Surgeon	19.20	16.00	3.20	16.67%
Psychologist-HF, (Safety)	37.23	36.00	1.23	3.30%
Rehabilitation Therapist	38.64	39.60	-0.96	-2.48%

**State Hospital Vacancy Totals as of 7/31/10**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Clinical Social Worker	41.26	36.00	5.26	12.75%
Sr. Psychiatrist	12.50	7.00	5.50	44.00%
Sr. Psychologist (Spvr and Spec)	10.00	7.00	3.00	30.00%
Staff Psychiatrist	40.07	37.00	3.07	7.66%
Supervising Psychiatric Social Worker	2.00	2.00	0.00	0.00%
Supervising Rehabilitation Therapist	4.00	4.00	0.00	0.00%
<b>Other</b>				
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0.00%
Assistant Director of Dietetics	4.00	4.00	0.00	0.00%
Audiologist	0.00	0.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%
Chief, Central Program Services	1.00	1.00	0.00	0.00%
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief Psychologist	1.00	1.00	0.00	0.00%
Clinical Dietitian/Pre-Reg. Clinical Dietitian	8.00	6.50	1.50	18.75%
Clinical Laboratory Technologist	4.00	3.00	1.00	25.00%
Coordinator of Nursing Services	1.00	0.00	1.00	100.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	2.00	2.00	0.00	0.00%
Dentist	1.00	1.00	0.00	0.00%
Dietetic Technician	2.00	2.00	0.00	0.00%
E.E.G. Technician	1.00	1.00	0.00	0.00%
Food Service Technician I and II	72.00	65.00	7.00	9.72%

**State Hospital Vacancy Totals as of 7/31/10**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Hospital Police Lieutenant	2.00	2.00	0.00	0.00%
Hospital Police Sergeant	6.00	4.00	2.00	33.33%
Hospital Police Officer	52.00	48.00	4.00	7.69%
Health Record Technician I	25.00	21.00	4.00	16.00%
Health Record Techn II Sp	6.00	6.00	0.00	0.00%
Health Record Techn II Sup	3.00	3.00	0.00	0.00%
Health Record Techn III	2.00	2.00	0.00	0.00%
Health Services Specialist	36.00	30.00	6.00	16.67%
Institution Artist Facilitator	1.00	0.80	0.20	20.00%
Medical Technical Assistant	0.00	0.00	0.00	0.00%
Medical Transcriber	5.00	4.00	1.00	20.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	1.00	1.00	0.00	0.00%
Nurse Instructor	4.00	4.00	0.00	0.00%
Nursing Coordinator	8.00	7.00	1.00	12.50%
Office Technician	41.00	38.00	3.00	7.32%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	17.60	14.60	3.00	17.05%
Pharmacist II	2.00	2.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	13.60	11.00	2.60	19.12%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Program Assistant	7.00	6.00	1.00	14.29%

**State Hospital Vacancy Totals as of 7/31/10**

<b>Identified Clinical Positions</b>	<b>Budgeted Positions</b>	<b>Filled Positions</b>	<b>Vacancies</b>	<b>Vacancy Rate</b>
Program Consultant (RT, PSW)	2.00	0.00	2.00	100.00%
Program Director	6.00	6.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0.00%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Public Health Nurse II/I	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Special Investigator	1.00	1.00	0.00	0.00%
Special Investigator, Senior	3.00	3.00	0.00	0.00%
Speech Pathologist I	0.00	0.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	6.00	6.00	0.00	0.00%
Teaching Assistant	0.00	0.00	0.00	0.00%
Vocational Services Instructor	2.00	2.00	0.00	0.00%

*\* 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 RNs and senior psychiatrists.

**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 March 7-11, 2011.
2. The Court Monitor's team is scheduled to tour Atascadero State Hospital October 18-22, 2010 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.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<b>C. Integrated Therapeutic and Rehabilitation Services Planning</b>		
	<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 maintained substantial compliance with all of the requirements of Section C.1 except for core WRPT attendance (C.1.h). However, the facility needs to correct some significant process deficiencies (see C.1.a) to ensure that progress is maintained.</li> <li>2. MSH has maintained an adequate WRP training and mentoring program that is sufficient to meet its needs.</li> <li>3. MSH had made further appropriate refinements in current programs to address the needs of individuals with cognitive and seizure disorders.</li> <li>4. At this stage, all four facilities have made sufficient progress in the assessment of the cognitive status of individuals and in meeting the treatment and rehabilitation needs of these individuals.</li> <li>5. MSH has continued to improve its Family Therapy Services.</li> <li>6. MSH has continued to show improvement in Mall organization and structure.</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

1. Interdisciplinary Teams		
C.1	<p>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>	<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 (February - July 2010)</li> <li>2. DMH WRP Observation Monitoring summary data (February - July 2010)</li> <li>3. DMH WRP Team Facilitator Observation Monitoring Form summary data (February - July 2010)</li> <li>4. MSH WRP Content Guidelines</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program I, unit 402) for 14-day review of KKK</li> <li>2. WRPC (Program V, unit 403) for quarterly review of OV</li> <li>3. WRPC (Program V, unit 405) for 14-day review of CL</li> <li>4. WRPC (Program V, unit 405) for 14-day review of JG</li> <li>5. WRPC (Program V, unit 413) for 14-day review of EE</li> <li>6. WRPC (Program V, unit 413) for 14-day review of KG</li> <li>7. WRPC (Program V, unit 413) for 14-day review of RR</li> <li>8. WRPC (Program II, unit 414) for monthly review of RS</li> <li>9. WRPC (Program III, unit 415) for monthly review of JA</li> <li>10. WRPC (Program III, unit 415) for monthly review of PGH</li> <li>11. WRPC (Program VI, unit 418) for monthly review of RS</li> <li>12. WRPC (Program VI, unit 419) for monthly review of KG (2)</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.a</p>	<p>Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the 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>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Provide a summary outline of all WRP training provided to the WRPTs during the reporting period. For each training the summary should include:             <ul style="list-style-type: none"> <li>○ Name of the training;</li> <li>○ Number of sessions offered;</li> <li>○ Schedule of training sessions;</li> <li>○ Specific focus of the training;</li> <li>○ Number of staff who attended vs. those who were required to attend;</li> <li>○ Criteria to determine existing staff who need further training;</li> <li>○ Facilitator(s) of training; and</li> <li>○ Outcome of any competency measures.</li> </ul> </li> </ul> <p><b>Findings:</b></p> <p>MSH continued the same training and mentoring processes that were described in the last report. The following is a summary of the facility's activities in this area during this review period:</p> <ol style="list-style-type: none"> <li>1. All new clinical employees and existing WRP members who required attendance received the WRP comprehensive training class. Training occurred monthly with the exception of March and May. From February 2010 to July 2010, 56 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. Training needs for existing WRPT staff were determined by audit data and supervisor recommendation. All WRPT members scored 90% or higher in a competency examination.</li> <li>2. Recovery training was offered monthly to a total 551 employees, both new and enduring. Competency was evidenced by test results of 90%</li> </ol>
--------------	---	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>or higher. Training needs were determined by yearly recertification, supervisor recommendation, and failure to pass competency. 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. This differed from the more generalized delivery of Recovery in the Comprehensive WRP training class.</p> <ol style="list-style-type: none"> <li>3. The Chief of Social Service provided individual training to social workers identified as in need of training as a result of audit and observation. Four social workers were identified. Attendance was mandatory. Competency was determined by the participant's ability to demonstrate modification of life goals, barriers to discharge, and formulation of objectives and interventions within the Wellness and Recovery Plan. All Social Work staff trained scored 100% on follow-up competency audits. Further training needs for Social Work staff were determined by supervisor recommendation and audit data analysis. No additional discipline-specific training was provided during this review period.</li> <li>4. The WRP Team Mentoring Program was continued each Tuesday from March 2010 to June 2010. The MSH admission unit (405/410) psychiatrists attended in vivo training with identified mentors including the Assistant Medical Director, Nady Hanna, MD and the Chief of Psychiatry, Bala Gulasekaram, MD. Competency was assured by return demonstration. During this review period, the mentoring program focused on WRPTs identified as needing additional support.</li> <li>5. Additional computer training was offered for staff needing more basic computer introduction and to address specific WaRMSS functioning issues. This training was provided on a monthly basis for a total of 22 enduring employees. Training needs for staff were determined by supervisor recommendation and employee request. Competency was evidenced by in-class return demonstration.</li> <li>6. An in-facility WaRMSS help desk is available to staff daily for one-on-one consultation and problem resolution. Keven Buckheim, Single</li> </ol>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Point of Contact for WaRMSS, has been available by request. On average, 20 calls per week were addressed with durations from a few moments to an hour or more dependent on each situation.</p> <p>7. By Choice training continued from the last review period and was offered monthly and attended by a total 343 employees, both new and enduring. Training needs for enduring staff were determined by yearly recertification, supervisor recommendation, and failure to pass competency. Competency was evidenced by testing with each participant earning a grade of 90% or higher.</p> <p>In addition to the above processes, the facility implemented a process of WRP updates during the period of June 28-July 2. Materials were presented by the WRP master trainer based on the "WRP Content Guide" developed at MSH by the Treatment Enhancement Coordinator, Ashvind Singh, PhD and Assistant Medical Director, Nady Hanna, MD. The materials included improved clinical examples of foci, objectives and interventions and all sections of the case formulation. These updates were provided to 137 enduring staff and competency was assessed by role play, in-class discussion, and 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 (February-July 2010):</p> <table border="1" data-bbox="976 1079 1879 1414"> <tr> <td data-bbox="976 1079 1071 1226">1.</td> <td data-bbox="1071 1079 1785 1226"><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="1785 1079 1879 1226">98%</td> </tr> <tr> <td data-bbox="976 1226 1071 1414">2.</td> <td data-bbox="1071 1226 1785 1414"><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="1785 1226 1879 1414">97%</td> </tr> </table>	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>	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>	97%
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>	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>	97%						

		<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. In general, the meetings showed that MSH has maintained substantial compliance with the requirement regarding the process of the conference. However, the following deficiencies were noted and they must be corrected because of their potential to compromise progress made thus far:</p> <ol style="list-style-type: none"> <li>1. Some WRPTs get completely focused on a rigid process to the point of losing sight of the changing or current needs of their individuals, which is the real purpose of the process. In one meeting, the WRPT made statements during the conference about the individual's current status that were contradicted by the individual's behavior during a behavioral emergency (that occurred on the unit at the same time as the meeting and the team would not interrupt the meeting to attend to the individual because they were "being monitored").</li> <li>2. In two meetings, the team leaders had difficulties in the proper approach to individuals who were openly delusional and/or arguing or disagreeing with their diagnosis and treatment during the conference. Some of the current approaches were provocative rather than calming to the individuals.</li> </ol> <p><b>Compliance:</b>          Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Correct the above-mentioned deficiencies 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</li> </ol>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>efforts to streamline the WRP content.</p> <ol style="list-style-type: none"> <li>2. Provide an update of WRP training and mentoring activities during the reporting period.</li> <li>3. Continue to monitor this requirement.</li> </ol>															
C.1.b	<p>Be led by a clinical professional who is involved in the care of the individual.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="982 748 1879 824"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>Each team is led by a clinical professional who is involved in the care of the individual.</i></td> <td style="width: 15%;">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>The facility also used the DMH WRP Team Facilitator Observation Monitoring Form to assess its compliance, based on an average sample of 53% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 1157 1879 1421"> <tr> <td style="width: 5%;">1.</td> <td style="width: 80%;"><i>The team psychiatrist was present.</i></td> <td style="width: 15%;">100%</td> </tr> <tr> <td>2.</td> <td><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The team facilitator ensured that the interventions</i></td> <td>99%</td> </tr> </table>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%	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>	99%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%															
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>	99%															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="text-align: center;"><i>were linked to the objectives.</i></td> <td style="width: 10%;"></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>Other findings:</b> This monitor's observations of WRPCs (see C.1.a) indicated that, in at least one meeting, the team facilitator did not comply with item 3 above.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as in Recommendations 1 and 3 in C.1.a.</p>		<i>were linked to the objectives.</i>	
	<i>were linked to the objectives.</i>				
C.1.c	Function in an interdisciplinary fashion.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">2.</td> <td style="text-align: center;"><i>Each team functions in an interdisciplinary fashion.</i></td> <td style="width: 10%; text-align: center;">95%</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><b>Compliance:</b> Substantial.</p>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	95%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	95%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.1.d	<p>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Audit, MSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="982 673 1877 824"> <tr> <td data-bbox="982 673 1075 824">1.</td> <td data-bbox="1075 673 1780 824"><i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1780 673 1877 824">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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	98%
1.	<i>The WRP Team assumes primary responsibility for the individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	98%			
C.1.e	<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, March 2010:</b> Continue to monitor this requirement</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="982 376 1877 565"> <tr> <td data-bbox="982 376 1075 565">3.</td> <td data-bbox="1075 376 1780 565"><i>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.</i></td> <td data-bbox="1780 376 1877 565">91%</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><b>Other findings:</b> This monitor's observations of WRPCs (see C.1.a) found that in at least one meeting, the team facilitator did not comply with item 3 above.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Same as Recommendations 1 and 3 in C.1.a.</p>	3.	<i>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.</i>	91%
3.	<i>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.</i>	91%			
C.1.f	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 94% for the review period. Comparative data indicated that MSH has maintained a compliance rate of</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>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, March 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 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="982 857 1877 1045"> <tr> <td data-bbox="982 857 1075 1045">5.</td> <td data-bbox="1075 857 1780 1045"><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></td> <td data-bbox="1780 857 1877 1045">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><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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>	100%
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>	100%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.1.h	<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, March 2010:</b> Continue efforts to increase attendance of WRPT members at WRPCs.</p> <p><b>Findings:</b> MSH presented core WRPT member attendance data based on an average sample of 21% of quarterly and annual WRPCs held during the review period (February-July 2010):</p> <table border="1" data-bbox="978 561 1801 1057"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>Individual</td> <td>87%</td> <td>85%</td> </tr> <tr> <td>Psychiatrist</td> <td>99%</td> <td>100%</td> </tr> <tr> <td>Psychologist</td> <td>67%</td> <td>83%</td> </tr> <tr> <td>Social Worker</td> <td>81%</td> <td>91%</td> </tr> <tr> <td>Rehabilitation Therapist</td> <td>85%</td> <td>91%</td> </tr> <tr> <td>Registered Nurse</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>92%</td> <td>91%</td> </tr> <tr> <th></th> <th>Last month previous period</th> <th>Last month current period</th> </tr> <tr> <td>Individual</td> <td>71%</td> <td>93%</td> </tr> <tr> <td>Psychologist</td> <td>67%</td> <td>98%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Partial; improved compared to last review.</p> <p><b>Current recommendation:</b> Continue efforts to increase attendance of all WRPT members at WRPCs.</p>		Previous review period	Current review period	Individual	87%	85%	Psychiatrist	99%	100%	Psychologist	67%	83%	Social Worker	81%	91%	Rehabilitation Therapist	85%	91%	Registered Nurse	99%	99%	Psychiatric Technician	92%	91%		Last month previous period	Last month current period	Individual	71%	93%	Psychologist	67%	98%
	Previous review period	Current review period																																	
Individual	87%	85%																																	
Psychiatrist	99%	100%																																	
Psychologist	67%	83%																																	
Social Worker	81%	91%																																	
Rehabilitation Therapist	85%	91%																																	
Registered Nurse	99%	99%																																	
Psychiatric Technician	92%	91%																																	
	Last month previous period	Last month current period																																	
Individual	71%	93%																																	
Psychologist	67%	98%																																	
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</p>	<p><b>Current findings on previous recommendation:</b></p>																																	

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>average, 1:25 in all other teams at any point in time.</p>	<p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="982 414 1669 1026"> <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>1:16</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>1:16</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>1:23</td> </tr> <tr> <td>PhDs</td> <td>1:25</td> <td>1:23</td> </tr> <tr> <td>SWs</td> <td>1:22</td> <td>1:22</td> </tr> <tr> <td>RTs</td> <td>1:22</td> <td>1:24</td> </tr> <tr> <td>RNs</td> <td>1:17</td> <td>1:23</td> </tr> <tr> <td>PTs</td> <td>1:18</td> <td>1:22</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous review period	Current review period	Admission Units			MDs	1:15	1:15	PhDs	1:16	1:15	SWs	1:15	1:15	RTs	1:15	1:15	RNs	1:15	1:15	PTs	1:16	1:15	Long-Term Units			MDs	1:23	1:23	PhDs	1:25	1:23	SWs	1:22	1:22	RTs	1:22	1:24	RNs	1:17	1:23	PTs	1:18	1:22
	Previous review period	Current review period																																													
Admission Units																																															
MDs	1:15	1:15																																													
PhDs	1:16	1:15																																													
SWs	1:15	1:15																																													
RTs	1:15	1:15																																													
RNs	1:15	1:15																																													
PTs	1:16	1:15																																													
Long-Term Units																																															
MDs	1:23	1:23																																													
PhDs	1:25	1:23																																													
SWs	1:22	1:22																																													
RTs	1:22	1:24																																													
RNs	1:17	1:23																																													
PTs	1:18	1:22																																													

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.1.j</p>	<p>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 recommendation:</b> Same as C.1.a through C.1.f.</p>
--------------	---	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

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. Andrea Ciota, Acting Rehabilitation Therapy Chief</li> <li>2. Ashvind Singh, PhD, Psychologist, Treatment Enhancement Coordinator</li> <li>3. Chris Marshall, Director of Nutrition Services</li> <li>4. Christina Rim, MD, Staff Psychiatrist</li> <li>5. Darren Sush, PsyD, PBS Team Leader, PSSC Coordinator</li> <li>6. David Daniels, RD</li> <li>7. David Estrada, MD, Psychiatrist</li> <li>8. Denise Manos, Assistant Director of Nutrition Services</li> <li>9. Derek Wangberg, PhD, Psychologist</li> <li>10. Don Magner, PT</li> <li>11. Donald Wagner, PT</li> <li>12. Donna Gilland, Program Director</li> <li>13. Eburn Collier-Carter, RN</li> <li>14. Goodness Izima, RN</li> <li>15. Gretchen Hunt, By Choice Coordinator</li> <li>16. Ivan Mendez, SW</li> <li>17. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>18. John Lusch, Mall Director</li> <li>19. Jonathan Fogel, PhD, Psychologist</li> <li>20. Keven Buckheim, PhD, Psychologist, Assistant Treatment Enhancement Coordinator</li> <li>21. Laura Dardashti, MD, Staff Psychiatrist</li> <li>22. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>23. Marlene Villasenor, RT</li> <li>24. Mary Ramirez, Assistant Director of Nutrition Services</li> <li>25. Mary Uribe, PT</li> <li>26. Michael Barsom, MD, Medical Director</li> <li>27. Michael Simmons, PSW</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>28. Monica Reyes, RN                  29. Nady Hanna, MD, Assistant Medical Director                  30. Portia Salvacion, Assistant Director of Nutrition Services                  31. Queen Igbonagwam, RN, PBS team                  32. Rebecca McClary, Acting Supervising Rehabilitation Therapist                  33. Robert Lindstrom, DO, Physician                  34. Ruth Flores, Supervisor of Vocational Services                  35. Sean Johnson, By Choice Program staff                  36. Sharon Smith Nevins, Executive Director                  37. Sheri Greve, PsyD, Acting Chief of Psychology                  38. Siobhan Donovan, PsyD, Senior Psychologist                  39. Terez Henson, Supervising Rehabilitation Therapist                  40. Uthai Chaisri, By Choice Program staff                  41. Virginia A. Tovar, Assistant Director of Nutrition Services                  42. Willie Smith, RT,</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 91 individuals: AB, ALS, AM, AP, AS, BJB, BMW, BMY, BTB, BY, CAC, CC, CDR, CED, CLD, CLH, CP, CW, DC, DE, DGB, DH, EC, EEA, ES, FDA, FR, GA, GL, GS, HAN, HCA, HD, HF, HI, HQN, JA, JAC, JD, JEK, JGH, JH, JI, JK, JL, JLS, JM, JR-1, JR-2, JS, KDP, KL, KMC, LAB, MA, MEB, MF, MG, MLB, MLC, MMS, MP, NA, NR, OC, OLM, ORH, PC, PD, PL, RAM, RB, RHL, RM, RO, RS, SACC, SE-1, SE-2, SPR, SR, SS, TCC, TCG, VMC, WAS, WL, YBB, YSL, YVB and ZB</li> <li>2. WRP one per team for the following 26 individuals: AF, AP, ARG, CP, CWP, DRA, FR, JCB, JJW, JKF, JM, JRF, KDP, KMC, LO, PGH, RAM, RCA, RS, SAV, SDA, SS, TAE, TG, VA, and WAS</li> <li>3. Number of Cognitive Remediation Groups previous vs. current reporting period and list of improvements made during review period.</li> <li>4. WRP and corresponding Focus 1 and Focus 3 PSR Mall Progress Notes for five individuals; KLK, KMC, MA, MEB, and SE</li> <li>5. Focused Assessment - Cognitive Screening and Neuropsychological</li> </ol>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Evaluation for individual MSS</p> <ol style="list-style-type: none"> <li>6. The following C2.f.v lesson plans: <ul style="list-style-type: none"> <li>• Anger Management</li> <li>• Symptom Management</li> <li>• Medication Management</li> <li>• Coping Skills Group</li> </ul> </li> <li>7. The following Cognitive Remediation (formal and informal) group lesson plans: <ul style="list-style-type: none"> <li>• Cognitive Skills Training - Captain's Log</li> <li>• Brainwave-R: Cognitive Strategies and Techniques for Brain Injury Rehabilitation</li> <li>• Cognitive Skills Development: Know Your Abilities</li> <li>• Cognitive Awareness: Daily Living Skills</li> <li>• Cognitive Rehabilitation: Problem Solving</li> <li>• Cognitive Rehabilitation: Memory and Learning</li> <li>• Cognitive Remediation: Learning 2 Learn My Treatment Plan</li> </ul> </li> <li>8. DMH WRP Observation Monitoring summary data (February - July 2010)</li> <li>9. DMH Chart Auditing Form summary data (February - July 2010)</li> <li>10. DMH Clinical Chart Auditing Form summary data (February - July 2010)</li> <li>11. DMH Substance Abuse Auditing Form summary data (February - July 2010)</li> <li>12. Substance Abuse Clinical Outcome summary data (October 2009 - July 2010).</li> <li>13. Substance Abuse Process Outcome summary data (October 2009 - July 2010)</li> <li>14. Substance Abuse Individual Satisfaction Survey summary data (October 2009 - July 2010)</li> <li>15. PBS Behavior Guideline for VMC</li> <li>16. Substance Recovery Curriculum (Pre-Contemplation/Contemplation/Preparation Stage of Change) including lesson plans and class materials</li> </ol>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<ol style="list-style-type: none"> <li>17. Substance Recovery Curriculum (Preparation/Action/Maintenance Stage of Change) including lesson plans and class materials</li> <li>18. Focus 5 Stage of Change WRPT Training guide 11/2009</li> <li>19. Neuropsychology of Addiction Syllabus</li> <li>20. Hooked on Maintenance Lesson Plan</li> <li>21. Current individuals with substance abuse diagnosis</li> <li>22. DBT unit plan</li> <li>23. ETRC/PSSC meeting minutes</li> <li>24. List of individuals assessed to need Family Therapy</li> <li>25. List of individuals who have utilized higher than threshold levels</li> <li>26. List of individuals with civil commitments</li> <li>27. List of supplemental activities</li> <li>28. List showing medical appointment cancellation data</li> <li>29. Mall Schedules and Lesson Plans</li> <li>30. PSR services Course Outline</li> <li>31. Quality Council Meeting Minutes</li> <li>32. Trigger report</li> <li>33. Supplemental Activity list</li> <li>34. Unit Milieu Plan</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. PSR Mall Group: Coping Skills</li> <li>2. PSR Mall Group: Managing PTSD/Trauma Recovery</li> <li>3. PSR Mall Group: Neurobiology of Addiction (maintenance stage)</li> <li>4. PSR Mall Group: Substance Abuse Recovery</li> <li>5. PSR Mall Group: Substance Abuse Recovery - Pros and Cons</li> <li>6. PSR Mall Group: Substance Recovery (Stages 1, 2 and 3)</li> <li>7. WRPC (program II, unit 44) for monthly review of RS</li> <li>8. WRPC (Program V, unit 403) for quarterly review of OV</li> <li>9. WRPC (Program V, unit 405) for 14-day review of CL</li> <li>10. Discharge and Resource Planning</li> </ol>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 21% of the WRPCs held each month during the review period (February-July 2010). The following table summarizes the data:</p> <table border="1" data-bbox="991 597 1885 748"> <tr> <td data-bbox="991 597 1087 748">6.</td> <td data-bbox="1087 597 1793 748"><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td data-bbox="1793 597 1885 748">97%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%
6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%			
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.			
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<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 (February-July 2010). 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% since the last review.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) 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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Based on an average sample of 100% of the 7-day WRPs, the facility reported a mean compliance rate of 100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) found</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>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.iii	<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, March 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="993 784 1650 1015"> <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>76%</td> <td>97%</td> </tr> <tr> <td>Monthly</td> <td>15%</td> <td>91%</td> </tr> <tr> <td>Quarterly</td> <td>20%</td> <td>92%</td> </tr> <tr> <td>Annual</td> <td>21%</td> <td>93%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review for all time frames.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) found compliance in all cases.</p> <p><b>Compliance:</b> Substantial.</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	76%	97%	Monthly	15%	91%	Quarterly	20%	92%	Annual	21%	93%
WRP Review	Mean sample size	Mean compliance rate															
14-Day	76%	97%															
Monthly	15%	91%															
Quarterly	20%	92%															
Annual	21%	93%															

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.c	<p>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;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 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 100% samples of relevant populations due for quarterly or annual WRPs due during the review months (February-July 2010):</p> <table border="1" data-bbox="991 748 1885 935"> <tr> <td data-bbox="991 748 1087 935">2.</td> <td data-bbox="1087 748 1791 935"><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="1791 748 1885 935">97%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Recommendation 2, March 2010:</b> Ensure that lesson plans of all groups are converted into electronic form.</p> <p><b>Findings:</b> MSH did not address this recommendation.</p> <p><b>Recommendation 3, March 2010:</b> Improve the coordination between the departments of psychiatry, psychology, and Mall leadership regarding interventions that provide</p>	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>	97%
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>	97%			

		<p>cognitive remediation.</p> <p><b>Findings:</b> Staff interviews and review of the facility's data indicated that MSH has made sufficient progress in this area.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 13 individuals who were diagnosed with a variety of cognitive disorders (DH, EEA, GA, JEK, JM, NA, SPR and WL) and seizure disorders (CDR, GS, KDP, LAB and MMS). The reviews found evidence of continued progress in the following areas:</p> <ol style="list-style-type: none"> <li>1. Finalization of diagnosis for individuals suffering from dementias;</li> <li>2. Addressing the fall risk for individuals suffering from cognitive impairments;</li> <li>3. Performance of neuropsychological testing for individuals suffering from cognitive impairments and utilization of the information to update the diagnosis and/or select group assignments;</li> <li>4. Development of appropriate foci, objectives and/or interventions to address the needs of some individuals diagnosed with dementing illnesses, mental retardation and other cognitive impairments;</li> <li>5. No evidence of unjustified use long-term use of anticholinergic medications and benzodiazepines for individuals suffering from cognitive impairments;</li> <li>6. Provision of groups therapies that provide cognitive rehabilitation for all individuals diagnosed with cognitive impairments (that were reviewed by this monitor);</li> <li>7. The number and hours of groups that offer cognitive remediation or that address cognitive impairment as a secondary objective;</li> <li>8. Addressing the status of seizure activity during the interval for individuals diagnosed with seizure disorders (some charts, e.g. that of KDP, included evidence of model reviews);</li> <li>9. The use of objectives and interventions based on learning outcomes</li> </ol>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>for most individuals suffering from seizure disorders; and</p> <p>10. Attention to the risks of treatment with older generation anticonvulsant medications for individuals who are diagnosed with seizure disorders and demonstrate some cognitive deficits (evidenced by neuropsychological assessment). The best example was found in the chart of MMS.</p> <p>This monitor found that in some individuals who are non-adherent to all medications, including psychiatric and anticonvulsant medications (e.g. CDR), the WRPs addressed this behavior only under Focus 6 (medical conditions). Ideally, the problem of non-adherence should also be addressed under Focus 1 if the behavior is driven by the individual's psychiatric impairment.</p> <p>Regarding the care of individuals suffering from substance use disorders, this monitor found 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>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.d.i</p>	<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>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Improve documentation the (in the Present Status section) of planned modifications of treatment in response to the use of restrictive interventions</li> </ul> <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 (February-July 2010):</p> <table border="1" data-bbox="991 708 1885 857"> <tr> <td data-bbox="991 708 1087 857">3.</td> <td data-bbox="1087 708 1789 857"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1789 708 1885 857">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below.</p> <p><b>Other findings:</b> This monitor reviewed one WRP per WRPT for the following 26 individuals: AF, AP, ARG, CP, CWP, DRA, FR, JCB, JJW, JKF, JM, JRF, KDP, KMC, LO, PGH, RAM, RCA, RS, SAV, SDA, SS, TAE, TG, VA, and WAS. The review found general evidence that MSH has maintained substantial compliance with the requirements regarding the structure and content of the case formulation. DMH is currently in the process of streamlining of the WRP to minimize duplication between the WRPs and</p>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	99%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	99%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>the psychiatric progress notes. Henceforth, this monitor will assess the documentation of planned modifications of psychiatric treatment (for individuals who require the use of restrictive interventions) in the psychiatric progress notes.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. 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.</li> </ol>			
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	<table border="1"> <tr> <td>4.</td> <td><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	99%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	99%			
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	<table border="1"> <tr> <td>5.</td> <td><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	98%
5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	98%			
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;	<table border="1"> <tr> <td>6.</td> <td><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation</i></td> <td>98%</td> </tr> </table>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation</i>	98%
6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation</i>	98%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td></td> <td><i>interventions</i></td> <td></td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>		<i>interventions</i>	
	<i>interventions</i>				
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	<table border="1"> <tr> <td>7.</td> <td><i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists. There is a completed DSM IV-TR Checklist that supports the diagnosis</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>	7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists. There is a completed DSM IV-TR Checklist that supports the diagnosis</i>	99%
7.	<i>Support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists. There is a completed DSM IV-TR Checklist that supports the diagnosis</i>	99%			
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.	<table border="1"> <tr> <td>8.</td> <td><i>The case formulation enables 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.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>	8.	<i>The case formulation enables 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.</i>	99%
8.	<i>The case formulation enables 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.</i>	99%			
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 recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Chart Auditing Form, MSH assessed its compliance</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>based on an average sample of 20% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 302 1885 490"> <tr> <td data-bbox="991 302 1087 490">4.</td> <td data-bbox="1087 302 1791 490"><i>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).</i></td> <td data-bbox="1791 302 1885 490">91%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b>          This monitor reviewed the records of 10 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. Nine records were in substantial compliance (AS, BJB, DGB, HF, JA, JAC, JR, MMS and RM) and one record was not in compliance (FR).</p> <p>This monitor also reviewed the records of eight individuals who had IA:RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. Seven records were in substantial compliance (CC, CLH, HCA, JI, KL, MLC and PL) and one record was not in compliance (JS).</p> <p>Finally, this monitor reviewed the records of eight individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p>	4.	<i>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).</i>	91%
4.	<i>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).</i>	91%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<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 C.1.a.</li> </ol>			
C.2.f	<p>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, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>			
C.2.f.i	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 (February-July 2010):</p> <table border="1" data-bbox="989 1227 1887 1414"> <tr> <td>5.</td> <td><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not</i></td> <td>92%</td> </tr> </table>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not</i>	92%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that builds on the individuals strengths and addresses the individuals identified needs and, if any identified needs are not</i>	92%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="991 190 1885 267"> <tr> <td data-bbox="991 190 1087 267"></td> <td data-bbox="1087 190 1793 267"><i>addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1793 190 1885 267"></td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> A review of the charts of six individuals found substantial compliance in five (MA, MES, SE, TCC and WAS) and partial compliance in one (KMC). The chart of KMC included evidence of generic assessment of an individual's strengths (e.g. "utilizing his cooperative attitude").</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>addressed, provide a rationale for not addressing the need.</i>	
	<i>addressed, provide a rationale for not addressing the need.</i>				
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, March 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 an average sample of 20% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1230 1885 1382"> <tr> <td data-bbox="991 1230 1087 1382">6.</td> <td data-bbox="1087 1230 1793 1382"><i>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.)</i></td> <td data-bbox="1793 1230 1885 1382">93%</td> </tr> </table>	6.	<i>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.)</i>	93%
6.	<i>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.)</i>	93%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in all charts (KMC, MA, MES, SE, TCC and WAS).</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 recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 94%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in four charts (MEB, SE, TCC and WAS), partial compliance in one (KMC) and noncompliance in one (MA). Some of the charts included model examples of specific learned behavioral outcomes that align with the individual's needs. The main deficiency (in the chart of MA) was the use of a generic objective ("verbalize two possible side effects of medications") without apparent relevance to the individual's actual needs</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<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. Avoid the use of generic objectives that do not address the assessed needs of the individuals.</li> </ol>
C.2.f.iv	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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% since the last review.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals who were diagnosed with substance use disorders (KMC, MA, MEB, ORH, TCC and WAS). The reviews found substantial compliance in five charts (MA, MEB, ORH, TCC and WAS) and partial compliance in one (KMC).</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 consistency in differentiating the stages of preparation and contemplation in the formulation of objectives.</li> </ol>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.f.v</p>	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> The facility reported a mean compliance rate of 97%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> Chart reviews found substantial compliance in all cases (KMC, MA, MES, SE, TCC and WAS).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
<p>C.2.f.vi</p>	<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>Recommendation 1, March 2010:</b> 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.</p> <p><b>Findings:</b> This monitor reviewed the charts 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.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>The following table summarizes the monitor's findings:</p> <table border="1" data-bbox="991 264 1831 724"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>AM</td> <td>16</td> <td>18</td> <td>6.1</td> </tr> <tr> <td>CED</td> <td>15</td> <td>14</td> <td>8.5</td> </tr> <tr> <td>CLD</td> <td>20</td> <td>18</td> <td>5.5</td> </tr> <tr> <td>EC</td> <td>9</td> <td>21</td> <td>12</td> </tr> <tr> <td>JD</td> <td>13</td> <td>16</td> <td>11</td> </tr> <tr> <td>JH</td> <td>8</td> <td>13</td> <td>5.5</td> </tr> <tr> <td>MLB</td> <td>15</td> <td>32</td> <td>28</td> </tr> <tr> <td>RHL</td> <td>20</td> <td>20</td> <td>6.5</td> </tr> <tr> <td>RO</td> <td>20</td> <td>20</td> <td>16</td> </tr> <tr> <td>YSL</td> <td>20</td> <td>20</td> <td>1</td> </tr> </tbody> </table> <p>As shown in the table above, there is a discrepancy in the WRP scheduled hours and the MAPP scheduled hours for seven of the 10 individuals reviewed.</p> <p>Staff (Mall Director, TEC Coordinator, and TEC Assistant Coordinator) reported continued problem with the WaRMMS module.</p> <p><b>Recommendations 2 and 3, March 2010:</b></p> <ul style="list-style-type: none"> <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 is continuing to work with DMH to resolve WaRMMS system issues. Meanwhile, the facility has difficulty with the reliability of the data derived from the system.</p>	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	AM	16	18	6.1	CED	15	14	8.5	CLD	20	18	5.5	EC	9	21	12	JD	13	16	11	JH	8	13	5.5	MLB	15	32	28	RHL	20	20	6.5	RO	20	20	16	YSL	20	20	1
Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours																																											
AM	16	18	6.1																																											
CED	15	14	8.5																																											
CLD	20	18	5.5																																											
EC	9	21	12																																											
JD	13	16	11																																											
JH	8	13	5.5																																											
MLB	15	32	28																																											
RHL	20	20	6.5																																											
RO	20	20	16																																											
YSL	20	20	1																																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

MSH presented the following data on scheduled and attended hours; the mean number of individuals was 673 in each period:

Mean scheduled hours		
	Previous period	Current period
0-5	41	38
6-10	71	36
11-15	89	49
16-20	469	552

Mean attended hours		
	Previous period	Current period
0-5	48	40
6-10	93	39
11-15	120	73
16-20	412	522

As the tables above indicate, MSH's scheduled Mall hours for the 16-20 hours range has significantly increased since the last review period. The scheduled hours noted in the table above are quite similar to this monitor's findings from review of 10 randomly selected charts (AM, CED, CLD, EC, JD, JH, MLB, RHL, RO and YSL) and the MAPP schedule. However, the facility's Mall attended hours are at variance from the monitors findings from the same 10 randomly selected charts and MAPP data (please see table presented under recommendation 1, above).

**Compliance:**

Partial.

**Current recommendations:**

1. Address systemic issues that result in inconsistent/incorrect data in the WaRMMS database so that the database can serve as a source of

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>valid and reliable data for monitoring, analysis and decision-making.</p> <ol style="list-style-type: none"> <li>2. Continue to monitor hours of active treatment (scheduled and attended).</li> <li>3. 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> </ol>			
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, March 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 100% of quarterly and annual WRPs due in the review month for those individuals whose legal and clinical status allows for off-facility PSR Mall activities (February-July 2010):</p> <table border="1" data-bbox="993 857 1885 1008"> <tr> <td data-bbox="993 857 1087 1008">10.</td> <td data-bbox="1087 857 1791 1008"><i>Off-facility activities are scheduled in the interventions for those individuals whose legal and clinical status allows them to be off-facility for PSR Mall activities</i></td> <td data-bbox="1791 857 1885 1008">94%</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 charts of seven individuals who were admitted under civil commitment found substantial compliance in six charts (AB, BY, CP, ES, HD and JLS). Four of these individuals participate in off-site programming and two (BY and HD) do not. These two individuals have numerous dangerous behaviors that would be difficult to manage in the community (for example, AWOL, aggression, property destruction, and self-injurious behaviors). The record of one individual (MF) did not meet</p>	10.	<i>Off-facility activities are scheduled in the interventions for those individuals whose legal and clinical status allows them to be off-facility for PSR Mall activities</i>	94%
10.	<i>Off-facility activities are scheduled in the interventions for those individuals whose legal and clinical status allows them to be off-facility for PSR Mall activities</i>	94%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>compliance, as the individual was not participating in an off-site program even though the documentation did not indicate any dangerous behaviors that would be harmful to self and others when in the community for off-site visits..</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.f.viii	<p>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each 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>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on a mean sample of 20% of quarterly and annual WRPs due during the review period (February-July 2010):</p> <table border="1" data-bbox="991 971 1885 1305"> <tr> <td data-bbox="991 971 1087 1305">1.</td> <td data-bbox="1087 971 1791 1305"><i>Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each 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.</i></td> <td data-bbox="1791 971 1885 1305">94%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>	1.	<i>Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each 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.</i>	94%
1.	<i>Ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each 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.</i>	94%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>A review of the charts of six individuals found substantial compliance in all six (BY, CP, ES, HD, JLS and MF).</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>
C.2.g.i	<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 recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <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 five charts (MA, MEB, SE, TCC and WAS) and partial compliance in one (KMC). The chart of KMC did not document Focus 3, which appeared to</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>be indicated, nor make changes in objectives to address the current status of the individual.</p> <p>This monitor also reviewed the records of 10 individuals receiving direct occupational, physical, and speech 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 recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure consistency in revising objectives to address the changing needs of the individuals.</li> </ol>			
C.2.g.ii	<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 risk factors);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p><b>Findings:</b> Using the DMH WRP Clinical Chart Auditing Form, MSH assessed its compliance based on an average sample of 100% of individuals placed in seclusion and/or restraints each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1263 1885 1412"> <tr> <td data-bbox="991 1263 1087 1412">12.</td> <td data-bbox="1087 1263 1791 1412"><i>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</i></td> <td data-bbox="1791 1263 1885 1412">95%</td> </tr> </table>	12.	<i>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</i>	95%
12.	<i>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</i>	95%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="991 191 1885 232"> <tr> <td data-bbox="991 191 1087 232"></td> <td data-bbox="1087 191 1791 232"><i>risk factors)</i></td> <td data-bbox="1791 191 1885 232"></td> </tr> </table> <p data-bbox="991 272 1885 341">Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p data-bbox="991 386 1192 414"><b>Other findings:</b></p> <p data-bbox="991 418 1885 527">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 these reviews:</p> <table border="1" data-bbox="991 565 1885 868"> <thead> <tr> <th data-bbox="991 565 1157 641">Individual</th> <th data-bbox="1157 565 1518 641">Date of seclusion and/or restraint</th> <th data-bbox="1518 565 1885 641">Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 641 1157 678">AP</td> <td data-bbox="1157 641 1518 678">7/29/10</td> <td data-bbox="1518 641 1885 678">8/4/10</td> </tr> <tr> <td data-bbox="991 678 1157 716">JR</td> <td data-bbox="1157 678 1518 716">7/26/10</td> <td data-bbox="1518 678 1885 716">7/27/10</td> </tr> <tr> <td data-bbox="991 716 1157 753">MP</td> <td data-bbox="1157 716 1518 753">2/28/10</td> <td data-bbox="1518 716 1885 753">3/26/10</td> </tr> <tr> <td data-bbox="991 753 1157 790">OC</td> <td data-bbox="1157 753 1518 790">7/27 and 7/28/10</td> <td data-bbox="1518 753 1885 790">8/12/10</td> </tr> <tr> <td data-bbox="991 790 1157 828">SACC</td> <td data-bbox="1157 790 1518 828">6/28/10</td> <td data-bbox="1518 790 1885 828">7/12/10</td> </tr> <tr> <td data-bbox="991 828 1157 868">VMC</td> <td data-bbox="1157 828 1518 868">7/23/10</td> <td data-bbox="1518 828 1885 868">7/27/10</td> </tr> </tbody> </table> <p data-bbox="991 912 1885 1242">The review focused on the WRP 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 three charts (AP, JR and MP), partial compliance in two (OC and SACC) and noncompliance in one (VMC). In some of the charts (SACC and VMC), the WRPs did not address the use of seclusion/restraints that occurred during the interval while enumerating all episodes that occurred previously.</p> <p data-bbox="991 1286 1144 1347"><b>Compliance:</b> Substantial.</p>		<i>risk factors)</i>		Individual	Date of seclusion and/or restraint	Date of applicable WRP review	AP	7/29/10	8/4/10	JR	7/26/10	7/27/10	MP	2/28/10	3/26/10	OC	7/27 and 7/28/10	8/12/10	SACC	6/28/10	7/12/10	VMC	7/23/10	7/27/10
	<i>risk factors)</i>																									
Individual	Date of seclusion and/or restraint	Date of applicable WRP review																								
AP	7/29/10	8/4/10																								
JR	7/26/10	7/27/10																								
MP	2/28/10	3/26/10																								
OC	7/27 and 7/28/10	8/12/10																								
SACC	6/28/10	7/12/10																								
VMC	7/23/10	7/27/10																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<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 Present Status section of the WRPs does not lose track of episodes of seclusion/restraints during the WRP interval.</li> </ol>			
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, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue to monitor this requirement.</li> <li>• Ensure that discharge criteria consistently specify parameters of "psychiatric stability."</li> </ul> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 857 1887 1008"> <tr> <td data-bbox="991 857 1087 1008">7.</td> <td data-bbox="1087 857 1793 1008"><i>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.</i></td> <td data-bbox="1793 857 1887 1008">97%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p> <p><b>Other findings:</b> This monitor reviewed the charts of six individuals (and interviewed the staff psychiatrist providing care to one of these individuals) to assess the documentation of discharge criteria and the discussion of the individual's progress towards discharge. The review found substantial compliance in four charts (MEB, SE, TCC and WAS) and noncompliance in two (KMC and MA). The chart of WAS included a model review of</p>	7.	<i>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.</i>	97%
7.	<i>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.</i>	97%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>discharge criteria and discussion of progress towards discharge. The chart of KMC did not document a discussion of progress towards discharge. The chart of MA included a generic statement implying that the individual made no progress towards discharge because of "challenging criteria." However, discussion with the treating psychiatrist indicated that the individual was making progress but the criteria were not sufficiently individualized to capture this progress.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Ensure consistent documentation of individualized discharge criteria and of the individual's progress towards discharge.</li> </ol>			
C.2.g.iv	<p>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 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 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1192 1890 1305"> <tr> <td data-bbox="991 1192 1087 1305">8.</td> <td data-bbox="1087 1192 1793 1305"><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td data-bbox="1793 1192 1890 1305">93%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review.</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>This monitor's chart reviews found substantial compliance in all charts (KMC, MA, MEB, SE, TCC and WAS).</p> <p><b>Recommendation 2, March 2010:</b> Ensure that Mall notes are consistently filed in the charts or readily available to the WRPTs for review before or during WRPCs.</p> <p><b>Findings:</b> Mall notes were found in the charts reviewed by this monitor. See cell C.2.i.vii for other findings related to Mall notes.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	<p>Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.</p> <p>A number of cases with known risks appear to not have been properly assessed for services, the services were not timely, or the services were not revised based on the presenting problems. The number of triggers for assault and other challenging behaviors is much higher than the number of behavioral assessments conducted at the facility for this review period. The issue appears to be the decision to not follow through with a behavioral assessment under the assumption that the individual's challenging behaviors were due to non-social or mental illness-related causes. This assumption can be incorrect for all cases. It is possible that the mental illness can mask the instrumental learning of the behaviors or have multiply controlled functions. Even if behaviors are caused by mental illness-related factors, assessments can point to</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>ecological intervention strategies than can mediate the behaviors.</p> <p>This monitor found other examples where behavioral assessments were warranted:</p> <ul style="list-style-type: none"> <li>• EC has a history of assaultive behaviors, and a discharge criterion of not being assaultive and "... recognize triggers to aggressive behavior ...". Following the discharge criterion, documentation states "due to E's recent DTO ...". However, under the need for behavior guidelines and PBS plan, the statement reads "Mr. C does not appear to require a behavioral guideline at this time." This individual should have been referred for a behavioral assessment to address his assaultive history and to learn adaptive behaviors and coping skills. There is no justifiable reason to wait till he exhibits the behavior prior to making a referral for behavioral assessments and interventions.</li> <li>• PD has severe self-injurious/self-harm behavior and is enrolled in DBT. PD should also have a behavioral intervention for coping skills, stress reduction, and other alternate behaviors, as well as staff training on ways to handle problem behaviors through setting event and antecedent manipulation and de-escalation at the precursor phase of the behavior.</li> </ul>
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	<p><b>Compliance:</b> Substantial.</p>
C.2.i.i	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% of quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 375 1890 490"> <tr> <td data-bbox="991 375 1087 490">2.</td> <td data-bbox="1087 375 1793 490"><i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i></td> <td data-bbox="1793 375 1890 490">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 eight individuals found that seven individuals' needs were appropriately addressed through the foci, objectives, and PSR interventions (AB, BY, DC, JGH, JLS, MF and SE), and one individual's needs were not (EC). In the case of EC, there was no referral for behavioral assessment. Mall group was limited to nine hours, without any justification, even though the individual is "interested in going to the Mall," and the objective for assault was entered under Focus 11.</p> <p><b>Other findings:</b> This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	100%
2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	100%			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<b>Current findings on previous recommendation:</b>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Recommendation, March 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 (February-July 2010):</p> <table border="1" data-bbox="993 488 1887 565"> <tr> <td data-bbox="993 488 1087 565">7.</td> <td data-bbox="1087 488 1793 565"><i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i></td> <td data-bbox="1793 488 1887 565">94%</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 six individuals found that all six of the WRPs in the charts contained objectives written in a measurable/observable manner (AB, BY, CP, HD, JLS and MF).</p> <p>A review of the records of six individuals found that the objectives in six of the WRPs in the charts were directly linked to a relevant focus of hospitalization (BY, CP, ES, HD, JLS and MF).</p> <p><b>Current recommendation:</b> Monitor this requirement and present data.</p>	7.	<i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i>	94%
7.	<i>All objectives are written in a way that tells you what we will see or hear the individual doing.</i>	94%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> See C.2.f.viii.</p> <p><b>Findings:</b> See C.2.f.viii.</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<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 recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that the strengths are specific, individualized, aligned with the intervention and written in accordance with the DMH WRP Manual.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH WRP Mall Alignment Monitoring Form, MSH assessed its compliance based on an average sample of 10% of Mall group facilitators each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 784 1890 862"> <tr> <td>15.</td> <td><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</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 WRPs of nine individuals found that seven WRPs specified the strengths of the individual in all active interventions reviewed (CP, DE, ES, HD, JH, JLS and SE). The remaining two WRPs either failed to include strengths in all the active interventions reviewed, or the stated strength was not in accordance with the DMH WRP Manual (MF and AB).</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>	98%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	98%			
C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and	<p><b>Current findings on previous recommendation:</b></p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>readmission due to relapse, where appropriate;</p>	<p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Alignment Monitoring Form, MSH assessed its compliance based on observation of a mean sample of 10% of quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 524 1890 711"> <tr> <td data-bbox="993 524 1087 711">3.</td> <td data-bbox="1087 524 1795 711"><i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.</i></td> <td data-bbox="1795 524 1890 711">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 WRPs of six individuals found that the individual's vulnerabilities were documented in the case formulation section in five WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (AB, CP, JLS, MF and SE). This was not the case in the remaining WRP (HD).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.</i>	100%
3.	<i>The individual is currently assigned to a WRAP group or has completed a WRAP group that focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate.</i>	100%			
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b> Using the DMH WRP Mall Observation Monitoring Form, MSH assessed compliance based on an average sample of 10% of the Mall group facilitators each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 375 1887 451"> <tr> <td data-bbox="991 375 1087 451">16.</td> <td data-bbox="1087 375 1793 451"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1793 375 1887 451">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 nine individuals (AB, AM, DE, FDA, HQN, JH, JLS, MF and YBB) found that cognitive screening had been conducted in all nine cases as part of the Integrated Assessment: Psychology Section or as part of a Neuropsychological assessment.</p> <p>A review of documented cognitive levels for seven individuals in six Mall group observed by this monitor found that the group was cognitively appropriate for all seven individuals (AB, AM, DE, FDA, HQN, JH and YVB).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	98%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	98%			
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 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>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b> The facility did not present data for this recommendation.</p> <p>According to the TEC Director, MSH is unable to track Mall Progress Note completion at this time. The facility hopes to correct the software system to be able to track Mall Progress Note completion and present the data for the next review.</p> <p>A review of the charts of seven individuals found that six contained the required monthly progress notes (AM, DE, FDA, HQN, JH and YVB) for the month reviewed and one did not (AB). The progress notes continue to suffer from meaningful feedback to the WRPTs, especially in documenting the individual's progress on the objectives in the individual's WRP. All seven WRPs in the charts had incorporated information from the progress notes into the Present Status section of the individual's WRP.</p> <p><b>Other findings:</b> This monitor reviewed the records of 10 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct treatment) to assess compliance with the requirements of C.2.i.vii. Eight records were in substantial compliance (AS, BJB, DGB, FR, HF, JAC, MMS and RM) and two records were in partial compliance (JA and JR).</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. 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>2. Use the data from monthly Mall Progress Notes in the WRP review process.</li></ol>
--	--	--

Section C: Integrated Therapeutic and Rehabilitation Services Planning

<p>C.2.i.viii</p>	<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>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue the current practice of providing Mall services for 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.</li> <li>• Continue to provide/add groups as needed by the individuals.</li> </ul> <p><b>Findings:</b> MSH continues to meet EP requirements regarding the number of days and hours that Mall services are offered. The table below shows the number of Mall hours scheduled and provided for each month of this review period:</p> <table border="1" data-bbox="991 784 1776 1089"> <thead> <tr> <th></th> <th>Scheduled hours</th> <th>Provided hours</th> </tr> </thead> <tbody> <tr> <td>Feb</td> <td>14,290</td> <td>13,525</td> </tr> <tr> <td>Mar</td> <td>14,375</td> <td>13,875</td> </tr> <tr> <td>Apr</td> <td>13,585</td> <td>13,175</td> </tr> <tr> <td>May</td> <td>14,475</td> <td>11,725</td> </tr> <tr> <td>Jun</td> <td>13,500</td> <td>13,525</td> </tr> <tr> <td>Jul</td> <td>14,135</td> <td>12,425</td> </tr> <tr> <td>Mean</td> <td>14,104</td> <td>13,042</td> </tr> </tbody> </table> <p>For the period, an average of 92.5% of scheduled hours were provided.</p> <p>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.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		Scheduled hours	Provided hours	Feb	14,290	13,525	Mar	14,375	13,875	Apr	13,585	13,175	May	14,475	11,725	Jun	13,500	13,525	Jul	14,135	12,425	Mean	14,104	13,042
	Scheduled hours	Provided hours																								
Feb	14,290	13,525																								
Mar	14,375	13,875																								
Apr	13,585	13,175																								
May	14,475	11,725																								
Jun	13,500	13,525																								
Jul	14,135	12,425																								
Mean	14,104	13,042																								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH presented the following data:</p> <table border="1" data-bbox="993 488 1814 639"> <thead> <tr> <th colspan="7">Monthly Hours of Active Treatment Scheduled/Delivered</th> </tr> <tr> <th>Individual (Program)</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> </tr> </thead> <tbody> <tr> <td>CC (VI)</td> <td>32</td> <td>32</td> <td>10*</td> <td>10*</td> <td>10*</td> <td>N/A</td> </tr> </tbody> </table> <p>*Individual's medical status impacted his ability to be provided or engage in therapy</p> <p><b>Other findings:</b> MSH had one bed-bound individual (CC) during this review period. This monitor visited the SNF unit, and was told by the unit staff that CC was no longer at the facility. This monitor reviewed CC's chart and findings from the documentation are aligned with the facility's data. CC had been diagnosed with bipolar disorder, depression, paraplegia, neurogenic bladder, femur fracture, and other serious medical conditions. When possible, MSH had provided CC with enrichment activities, Mall activities, and By Choice points.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement and present data.</p>	Monthly Hours of Active Treatment Scheduled/Delivered							Individual (Program)	Feb	Mar	Apr	May	Jun	Jul	CC (VI)	32	32	10*	10*	10*	N/A
Monthly Hours of Active Treatment Scheduled/Delivered																							
Individual (Program)	Feb	Mar	Apr	May	Jun	Jul																	
CC (VI)	32	32	10*	10*	10*	N/A																	
C.2.i.x	routinely takes place as scheduled;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1-3, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that Mall groups and individual therapies are cancelled rarely, if ever.</li> </ul>																					

Section C: Integrated Therapeutic and Rehabilitation Services Planning

- Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.
- Ensure that administrators facilitate a minimum of one Mall group per week.

**Findings:**

MSH presented the following data regarding cancellation of Mall groups:

	Feb	Mar	Apr	May	Jun	Jul	Mean
Groups scheduled	2858	2875	2717	2949	2700	2827	2821
Groups cancelled	257	288	271	590	270	339	228
Cancellation rate	9%	10%	10%	20%	10%	12%	12%

The mean cancellation rate was 11% 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 ADMIT (4)	2	2
Psychiatry L-T (8)	2.5	3.5
Psychology ADMIT (5)	4	2.5
Psychology L-T (10)	7.0	6
Social Work ADMIT (5)	2.8	3.5
Social Work L-T (10)	8	8
Rehab Therapy ADMIT (7)	6	6
Rehab Therapy L-T (15)	14.5	14

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td>Nursing (10)</td> <td>4.5</td> <td>5</td> </tr> </table>	Nursing (10)	4.5	5																													
Nursing (10)	4.5	5																																
		<table border="1"> <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>106</td> <td>90</td> <td>85%</td> </tr> <tr> <td>Psychology</td> <td>244</td> <td>163</td> <td>67%</td> </tr> <tr> <td>Social Work</td> <td>303</td> <td>248</td> <td>82%</td> </tr> <tr> <td>Rehab Therapy</td> <td>436</td> <td>349</td> <td>80%</td> </tr> <tr> <td>Nursing</td> <td>978</td> <td>635</td> <td>65%</td> </tr> <tr> <td>Other</td> <td>214</td> <td>120</td> <td>56%</td> </tr> <tr> <td>Administration</td> <td>48</td> <td>29</td> <td>60%</td> </tr> </tbody> </table> <p><b>Findings:</b> As the data in the table above show, the disciplines are providing between 56% and 85% of their required Mall facilitation hours. According to the Mall Director, furlough days, and summer season staff vacations have also affected staff participation in Mall group facilitation for this review period.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that Mall groups and individual therapies are cancelled rarely, if ever.</li> <li>2. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.</li> <li>3. Ensure that administrators facilitate a minimum of one Mall group per week.</li> </ol>	Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled	Psychiatry	106	90	85%	Psychology	244	163	67%	Social Work	303	248	82%	Rehab Therapy	436	349	80%	Nursing	978	635	65%	Other	214	120	56%	Administration	48	29	60%
Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled																															
Psychiatry	106	90	85%																															
Psychology	244	163	67%																															
Social Work	303	248	82%																															
Rehab Therapy	436	349	80%																															
Nursing	978	635	65%																															
Other	214	120	56%																															
Administration	48	29	60%																															
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, March 2010:</b> Provide data from the Supplemental Activities Module addressing the</p>																																

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>hours of supplemental activities programmed and held as well as participation by individuals.</p> <p><b>Findings:</b> The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 414 1879 652"> <thead> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1,548</td> <td>1,830</td> <td>1,661</td> <td>1,665</td> <td>1,771</td> <td>1,859</td> <td>10,334</td> </tr> <tr> <td>Hours provided</td> <td>1,263</td> <td>1,351</td> <td>1,084</td> <td>1,074</td> <td>1,383</td> <td>1,479</td> <td>7,634</td> </tr> <tr> <td>Compliance rate</td> <td>73%</td> <td>74%</td> <td>65%</td> <td>65%</td> <td>73%</td> <td>80%</td> <td>73%</td> </tr> </tbody> </table> <p>MSH continues to improve the supplemental activities offered to individuals. As the table above indicates, the facility provided between 65% and 80% of its scheduled activities. A review of the program found that, on average, two hours and 30 minutes of activities are offered on weekdays and five hours and 45 minutes/day of activities are offered during the weekends. The rehabilitation staff provides training to the nursing staff on operating the activities.</p> <p><b>Current recommendation:</b> Continue current practice.</p>		Feb	Mar	Apr	May	Jun	Jul	Mean	Hours scheduled	1,548	1,830	1,661	1,665	1,771	1,859	10,334	Hours provided	1,263	1,351	1,084	1,074	1,383	1,479	7,634	Compliance rate	73%	74%	65%	65%	73%	80%	73%
	Feb	Mar	Apr	May	Jun	Jul	Mean																											
Hours scheduled	1,548	1,830	1,661	1,665	1,771	1,859	10,334																											
Hours provided	1,263	1,351	1,084	1,074	1,383	1,479	7,634																											
Compliance rate	73%	74%	65%	65%	73%	80%	73%																											
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, March 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</p>																																

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>42% of the a.m. and p.m. shifts on units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 302 1887 1092"> <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>94%</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>58%</td> </tr> <tr> <td>4.</td> <td><i>The posted unit rules reflect recovery language and principles.</i></td> <td>73%</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>68%</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>99%</td> </tr> <tr> <td>7.</td> <td><i>Staff is observed actively engaged with the individuals.</i></td> <td>99%</td> </tr> <tr> <td>8.</td> <td><i>Staff interacts 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>100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for items 1, 2 and 7-10. Compliance improved for the remaining items as follows:</p>	1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	94%	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>	58%	4.	<i>The posted unit rules reflect recovery language and principles.</i>	73%	5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	68%	6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	99%	7.	<i>Staff is observed actively engaged with the individuals.</i>	99%	8.	<i>Staff interacts 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>	100%
1.	<i>During the 30-min observation, there is more staff in the milieu than in the nursing station.</i>	94%																														
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>	58%																														
4.	<i>The posted unit rules reflect recovery language and principles.</i>	73%																														
5.	<i>The bulletin boards have any postings, literature, or materials that reflect religious or cultural activities.</i>	68%																														
6.	<i>Staff interacts with individuals, discusses various subjects, and refrains from openly discussing confidential subject matter.</i>	99%																														
7.	<i>Staff is observed actively engaged with the individuals.</i>	99%																														
8.	<i>Staff interacts 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>	100%																														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1" data-bbox="993 228 1892 651"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Mean compliance rate</b></td> </tr> <tr> <td>3.</td> <td>44%</td> <td>58%</td> </tr> <tr> <td>4.</td> <td>65%</td> <td>73%</td> </tr> <tr> <td>5.</td> <td>63%</td> <td>68%</td> </tr> <tr> <td>6.</td> <td>75%</td> <td>99%</td> </tr> <tr> <td colspan="3"><b>Compliance rate in last month of period</b></td> </tr> <tr> <td>3.</td> <td>50%</td> <td>52%</td> </tr> <tr> <td>4.</td> <td>60%</td> <td>59%</td> </tr> <tr> <td>5.</td> <td>60%</td> <td>62%</td> </tr> </tbody> </table> <p><b>Other findings:</b> A review of the charts of six individuals found that all six contained milieu interventions appropriate to the active intervention (AM, BA, DE, FDA, HQN and YVB).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		Previous period	Current period	<b>Mean compliance rate</b>			3.	44%	58%	4.	65%	73%	5.	63%	68%	6.	75%	99%	<b>Compliance rate in last month of period</b>			3.	50%	52%	4.	60%	59%	5.	60%	62%
	Previous period	Current period																														
<b>Mean compliance rate</b>																																
3.	44%	58%																														
4.	65%	73%																														
5.	63%	68%																														
6.	75%	99%																														
<b>Compliance rate in last month of period</b>																																
3.	50%	52%																														
4.	60%	59%																														
5.	60%	62%																														
C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Track and review participation of individuals in scheduled group exercise and recreational activities.</p> <p><b>Findings:</b> The facility presented the following data:</p>																														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		Exercise Groups Offered vs. Needed						
			Feb	Mar	Apr	May	Jun	Jul
		Number of groups offered	14	14	12	13	13	12
		Number of groups needed	14	14	12	13	13	12
		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	95	95	100%			
		31 - 35	43	40	77%			
		36 - 40	19	19	100%			
>40	20	20	100%					
<p>As the tables above show, MSH offered the necessary exercise groups for the individuals needing the opportunity to participate in them. The facility has also enrolled most of the individuals with high BMIs to one or more exercise groups.</p> <p>Documentation review found that the facility offered the following groups: exercise, strength training, Walking for Cardio health, and fun and fitness groups. Each exercise group had a minimum of two staff and in some cases as many as three.</p> <p><b>Recommendation 2, March 2010:</b> Implement corrective action if participation is low.</p> <p><b>Findings:</b> The facility did not present data on participation. Participation should be</p>								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>tracked and monitored to enable understanding on progress or lack thereof and to take corrective actions.</p> <p>A review of the charts of six individuals with high BMIs (CP, JD, JH, RHL, RO and YSL) found that all six individuals were enrolled in exercise groups and their status was discussed in the Present Status section of the WRPs.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Track and review participation of individuals in scheduled group exercise and recreational activities.</li> <li>2. Implement corrective action if participation is low.</li> </ol>						
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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH C2k Family Therapy Auditing Form, MSH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact:</p> <table border="1" data-bbox="991 1190 1890 1412"> <tr> <td data-bbox="991 1190 1087 1341">1.</td> <td data-bbox="1087 1190 1793 1341"><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="1793 1190 1890 1341">97%</td> </tr> <tr> <td data-bbox="991 1341 1087 1412">2.</td> <td data-bbox="1087 1341 1793 1412"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to</i></td> <td data-bbox="1793 1341 1890 1412">96%</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>	97%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to</i>	96%
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>	97%						
2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to</i>	96%						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></p>	
		<p>3. <i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></p>	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>Social Work staff interviews and documentation review found that family therapy needs assessments are conducted via screening upon admission, annual assessments, information contained in the individuals' WRPs, and by attending the ETRC/PSSC meetings. SW continues to offer family services groups on the compound, and five families had participated in these meetings during this review period.</p> <p>MSH has produced the "Family Therapy" manual in English and Spanish. The Mall group "My Family My Support" continues to be offered for individuals in need of family therapy services.</p> <p>This monitor reviewed charts of eight individuals (BMY, CP, DE, FDA, HD, JGH, JLS and SR). All eight individuals and/or their families were receiving family therapy education and/or services. For example, SR's family is receiving information about SR regularly through contact with the mother; JGH's sister is being educated on matters relating to restoration via phone contacts; DE's mother keeps phone contact and attends NAMI meetings and DE is in the "My Family My Support"; HD's mother has limited contact with HD and day passes had been arranged</p>			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>for visitation; BMY's grandmother is engaged with staff and has presented information regarding BMY's previous admission and living arrangements; Social Work had communicated with FDA's mother and continues to update the mother on FDA's progress; JLS and his mother have poor communication with each other and Social Work staff works with them on improving their communication and JLS has an objective and intervention for improving communication with his family; and for CP the Social Work staff maintains communication with the aunt.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>												
C.2.1	<p>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 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>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integration of Medical Conditions in WRP Audit, MSH assessed its compliance based on a 21% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (February-July 2010):</p> <table border="1" data-bbox="991 1154 1892 1416"> <tr> <td data-bbox="991 1154 1087 1227">1.</td> <td data-bbox="1087 1154 1793 1227"><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td data-bbox="1793 1154 1892 1227">93%</td> </tr> <tr> <td data-bbox="991 1227 1087 1300">2.</td> <td data-bbox="1087 1227 1793 1300"><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td data-bbox="1793 1227 1892 1300">98%</td> </tr> <tr> <td data-bbox="991 1300 1087 1373">3.</td> <td data-bbox="1087 1300 1793 1373"><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td data-bbox="1793 1300 1892 1373">92%</td> </tr> <tr> <td data-bbox="991 1373 1087 1416">4.</td> <td data-bbox="1087 1373 1793 1416"><i>There is an appropriate objective for each medical</i></td> <td data-bbox="1793 1373 1892 1416">97%</td> </tr> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	93%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	98%	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</i>	97%
1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	93%												
2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	98%												
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</i>	97%												

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td></td> <td><i>condition or diagnosis.</i></td> <td></td> </tr> </table>		<i>condition or diagnosis.</i>		
	<i>condition or diagnosis.</i>					
		<table border="1"> <tr> <td>5.</td> <td><i>There are appropriate interventions for each objective.</i></td> <td>96%</td> </tr> </table>	5.	<i>There are appropriate interventions for each objective.</i>	96%	
5.	<i>There are appropriate interventions for each objective.</i>	96%				
		<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 (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found that MSH has continued to make significant improvements since the last review from the ongoing training and mentoring regarding the development of adequate and appropriate nursing objectives and interventions for Focus 6. The majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions, which comports with MSH's data.</p> <p>MSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on a sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months:</p>				
		<table border="1"> <tr> <td>6.</td> <td><i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i></td> <td>93%</td> </tr> </table>	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	93%	
6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.</i>	93%				
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period. See F.8.a.i and F.9.e for reviewer's findings related to individual-specific goals and objectives addressing refusals.</p> <p><b>Compliance:</b> Substantial.</p>				

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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, March 2010:</b> Same as in C.2.o.</p> <p><b>Findings:</b> Same as in C.2.o.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Same as in C.2.o.</p>
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally	<p><b>Current findings on previous recommendations:</b></p>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>accepted professional standards of care.</p>	<p><b>Recommendation 1, March 2010:</b> Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the past period).</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 20% of individuals with a current diagnosis of substance abuse (February-July 2010):</p> <table border="1" data-bbox="991 597 1885 1123"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>91%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td>92%</td> </tr> <tr> <td>3.</td> <td><i>There is at least one objective related to the individual's stage of change.</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>92%</td> </tr> <tr> <td>5.</td> <td><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td>91%</td> </tr> <tr> <td>6.</td> <td><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td>94%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the last review for all items.</p> <p><b>Recommendation 2:</b> Provide process and clinical outcome data relevant to SA services including comparisons with the previous review period.</p>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	91%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	92%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	96%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	92%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	91%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	94%
1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	91%																		
2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	92%																		
3.	<i>There is at least one objective related to the individual's stage of change.</i>	96%																		
4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	92%																		
5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	91%																		
6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	94%																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Findings:</b>  MSH presented an initial set of outcome data that were incomplete and internally inconsistent. Following the tour, the facility revised the data at the request of this monitor. The revised data were more complete and appeared to correct the inconsistencies. However, the data for October-December 2009 included inconsistencies with the data presented for the same quarter during the previous review period. It is worth mentioning that MSH has not ensured stability in the leadership of substance use services. In nine tours of this facility, seven or eight different section leaders have presented data for substance use services. This instability has deprived the facility of necessary longitudinal perspective, which is needed for consistency of indicators and adequate data gathering, assessment and analysis. This is unacceptable at this stage. With these limitations in mind, the following outlines the facility's data, excluding the data for October to December 2009:</p> <table border="1" data-bbox="989 820 1908 1424"> <thead> <tr> <th></th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sept 2010</th> </tr> </thead> <tbody> <tr> <td>Process Outcomes</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Individuals with Substance Abuse Dx</td> <td>402</td> <td>405</td> <td>397</td> </tr> <tr> <td>Individuals referred for SAS Treatment</td> <td>402</td> <td>405</td> <td>397</td> </tr> <tr> <td>Individuals screened by SAS (%)</td> <td>89%</td> <td>92%</td> <td>92%</td> </tr> <tr> <td>Hours of SAS treatment offered per month</td> <td>248</td> <td>276</td> <td>272</td> </tr> <tr> <td>SAS sessions scheduled (monthly average)</td> <td>226</td> <td>263</td> <td>266</td> </tr> <tr> <td>%SAS sessions held (monthly average)</td> <td>91%</td> <td>95%</td> <td>94%</td> </tr> <tr> <td>Individuals enrolled in SAS treatment (monthly average)</td> <td>395</td> <td>401</td> <td>392</td> </tr> <tr> <td>Individuals enrolled in AA</td> <td>No data</td> <td>205</td> <td>267</td> </tr> <tr> <td>Individuals attending AA</td> <td>No</td> <td>102</td> <td>120</td> </tr> </tbody> </table>		Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010	Process Outcomes				Individuals with Substance Abuse Dx	402	405	397	Individuals referred for SAS Treatment	402	405	397	Individuals screened by SAS (%)	89%	92%	92%	Hours of SAS treatment offered per month	248	276	272	SAS sessions scheduled (monthly average)	226	263	266	%SAS sessions held (monthly average)	91%	95%	94%	Individuals enrolled in SAS treatment (monthly average)	395	401	392	Individuals enrolled in AA	No data	205	267	Individuals attending AA	No	102	120
	Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010																																											
Process Outcomes																																														
Individuals with Substance Abuse Dx	402	405	397																																											
Individuals referred for SAS Treatment	402	405	397																																											
Individuals screened by SAS (%)	89%	92%	92%																																											
Hours of SAS treatment offered per month	248	276	272																																											
SAS sessions scheduled (monthly average)	226	263	266																																											
%SAS sessions held (monthly average)	91%	95%	94%																																											
Individuals enrolled in SAS treatment (monthly average)	395	401	392																																											
Individuals enrolled in AA	No data	205	267																																											
Individuals attending AA	No	102	120																																											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

			data		
		Individuals enrolled in NA	No data	87	112
		Individuals attending NA	No data	34	30
		Individuals on wait list	No data	No data	No data
		Hours of staff training provided	14	5	20
		Number of staff trained	6	0	8
		Number of staff monitored for fidelity (re implementation of SAS curriculum)	12	10	No data
			Jan-Mar 2010	Apr-Jun 2010	Jul-Sept 2010
		Clinical Outcomes			
		N=Number enrolled 1st day of quarter	376	393	397
		Advanced at least one stage of change or sustained in maintenance.	38 10%	75 19%	No data
		Refused treatment or regressed at least one stage of change.	75 20%	63 16%	No data
		Did not advance in stage of change	263 70%	255 65%	No data
		Out to Court/Other	No data	No data	No data
		Discharged	36	53	58
		Pre/Post Test-Increase Mean	79%	80%	No data
		MSH also presented further data regarding the number of outcome assessments (Socrates A and D Assessments) in each stage of change (all assessments were provided in English, none in Spanish). During this			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>review period, eight individuals received expanded screenings for substance use needs.</p> <p>MSH reported that its Substance Abuse groups were primarily divided into two cohorts, one for individuals in Stages 1, 2, and 3, and another for individuals in Stages 3, 4, and 5. Also, during this reporting period, MSH psychologists developed two new groups designed for individuals in the maintenance stage.</p> <p>The facility's consumer satisfaction surveys data indicated that during the first calendar quarter of 2010, the majority of individuals agreed with the indicators of outcome (i.e. learning new skills, understanding of information and finding the groups helpful and the leaders respectful). However, during the second quarter of 2010, the majority of individuals disagreed with these indicators. MSH did not present an assessment/analysis of the decline in individuals' satisfaction during the second quarter.</p> <p><b>Other findings:</b> Same as in C.2.f.iv. In addition, this monitor and one of his experts attended three different substance use groups. In general, the groups demonstrated that the instructors had adequate command of their subjects, that lesson plans were appropriate and that some individuals were adequately engaged during the sessions. However, the groups showed some significant limitations due to lack of relevance, adequate engagement and practice during sessions.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure stability in leadership of Substance Use Services.</li> <li>2. Present process and clinical outcome data using consistent indicators</li> </ol>
--	--	---

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and methodology.</p> <ol style="list-style-type: none"> <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. Improve group interventions to ensure proper engagement of attendees, relevance to the needs of individuals and practice during sessions, as appropriate.</li> </ol>																										
C.2.p	<p>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of 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.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Mall Facilitator Observation Monitoring Form. MSH assessed its compliance based on an average sample of 10% of the clinical facilitators (RTs, psychologists, and social workers) managing groups each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 894 1885 1125"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>97%</td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>95%</td> <td>95%</td> </tr> <tr> <td>3.</td> <td><i>Instructional techniques</i></td> <td>99%</td> <td>95%</td> </tr> <tr> <td>4.</td> <td><i>Learning process</i></td> <td>91%</td> <td>93%</td> </tr> </tbody> </table> <p>Using the DMH Mall Facilitator Observation Monitoring Form MSH assessed compliance from observation of a 10% sample of all facilitators during the review months (February-July 2010):</p> <table border="1" data-bbox="991 1308 1885 1421"> <tbody> <tr> <td>1.</td> <td><i>The session starts and ends within 5 minutes of the designated starting and ending time.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>The facilitator greets participants to begin the</i></td> <td>97%</td> </tr> </tbody> </table>			Previous review period	Current review period	1.	<i>Instructional skills</i>	97%	95%	2.	<i>Course structure</i>	95%	95%	3.	<i>Instructional techniques</i>	99%	95%	4.	<i>Learning process</i>	91%	93%	1.	<i>The session starts and ends within 5 minutes of the designated starting and ending time.</i>	96%	2.	<i>The facilitator greets participants to begin the</i>	97%
		Previous review period	Current review period																									
1.	<i>Instructional skills</i>	97%	95%																									
2.	<i>Course structure</i>	95%	95%																									
3.	<i>Instructional techniques</i>	99%	95%																									
4.	<i>Learning process</i>	91%	93%																									
1.	<i>The session starts and ends within 5 minutes of the designated starting and ending time.</i>	96%																										
2.	<i>The facilitator greets participants to begin the</i>	97%																										

Section C: Integrated Therapeutic and Rehabilitation Services Planning

			<i>session.</i>	
		3.	<i>The facilitator reviews work from the prior session.</i>	93%
		4.	<i>The facilitator introduces the day's topic and goals.</i>	95%
		5.	<i>The facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	93%
		6.	<i>The facilitator makes an attempt to engage each participant during the group.</i>	98%
		7.	<i>The facilitator attempts to keep all participants "on task" during the session.</i>	98%
		8.	<i>The facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	98%
		9.	<i>The facilitator attempts to test the participants understanding.</i>	93%
		10.	<i>The facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	99%
		11.	<i>The facilitator summarizes the work done in the session.</i>	92%
		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>	97%
		13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	95%
		14.	<i>Lesson plan is available and followed.</i>	92%
		<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 five Mall groups (Managing PTSD-Trauma Recovery, Substance Abuse Recovery, Coping Skills, Substance Abuse</p>		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Recovery-Pros and Cons, Discharge and Resource Planning). 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>• Most groups had materials for distribution.</li> <li>• Attendance in the groups was between 40% and 90%</li> <li>• The rooms and group arrangements were appropriate for the lesson of the day.</li> <li>• The rate of presentation in the Substance Abuse group was rapid, and appeared to overwhelm the individuals. There was no checking for understanding. The co-facilitator was active and was able to give explanation to individuals who appeared confused.</li> <li>• The Coping Skills group had older and medically fragile individuals. The facilitators were very active and creative. They provided physical support to individuals who lacked the range of motion to throw a dice (big one made of a fuzzy material).</li> <li>• One major issue common across almost all the groups was not making sure that each and every individual was given the opportunity to respond or engage.</li> <li>• Many of the groups were conducted in a lecture format with the individuals listening for 10 to 15 minutes with occasional questions to certain individuals who were the active ones.</li> </ul> <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	<b>Current findings on previous recommendation:</b>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	<p>abuse counselors.</p>	<p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH presented the following data regarding the certification of Substance Abuse facilitators as of July 2010:</p> <table border="1" data-bbox="993 451 1896 602"> <tr> <td>Number of Substance Abuse Recovery (SAR) providers/co-providers</td> <td>121</td> </tr> <tr> <td>Number of certified SAR providers/co-providers</td> <td>121</td> </tr> <tr> <td>Percentage of SAR providers/co-providers who are certified</td> <td>100%</td> </tr> </table> <p>According to MSH, all Substance Abuse Recovery providers at the facility are trained and certified. According to the Mall Director, all substance abuse recovery facilitators passed the competency test. The substance abuse recovery group facilitators are to be re-evaluated and re-trained if necessary at the end of the fourth Mall term.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>	Number of Substance Abuse Recovery (SAR) providers/co-providers	121	Number of certified SAR providers/co-providers	121	Percentage of SAR providers/co-providers who are certified	100%
Number of Substance Abuse Recovery (SAR) providers/co-providers	121							
Number of certified SAR providers/co-providers	121							
Percentage of SAR providers/co-providers who are certified	100%							
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, March 2010:</b> Continue to track reasons for cancellation.</p> <p><b>Findings:</b> The facility provided the following data on scheduled and cancelled appointments:</p>						

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Missed Appointments Monitoring - Medical Services					
	Appointments		Reasons for Cancellation		
	Sched- uled	Cancelled	Staffing	Transpor- tation	Other
Feb 10	1,552	527			
Mar 10	1,758	573			
Apr 10	1,781	547			
May 10	1,530	389			
Jun 10	1,700	501			
Jul 10	1,745	492			
Total	10,066	3,029			

The table above shows a total of 10,066 appointments scheduled with a total of 3,029 appointments cancelled, resulting in a mean 33% cancellation rate during this review period (the mean cancellation rate during the previous period was 32%). The facility did not present a summary and analysis on the reasons for cancellation. The numbers in the table do not add up to the data found in the summary documents. For example, the total cancelled appointments on the February 1 to July 31, 2010 sheet totals only 2,966 and not 3,029 as given in the table.

Document review found that, just as in the previous reviews, patient refusal was the primary reason for cancelled appointments (2,208). Other reasons for cancellation included unavailability of patients (453), clinic cancellations (271), and incomplete appointments due to discharge

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>and treatment refusals (33). Only one appointment was cancelled due to shortage of staffing. The summary did not have a section for transportation. The cancellation due to patient "not available" appears as high. The facility should analyze the reasons and correct the situation, as they should for the other reasons for the cancellations.</p> <p>The Psychology department had analyzed the reasons for cancellations and had plans for interventions, but this appears to not have been followed through.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to track reasons for cancellation, and correct high cancellations.</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, March 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 (February-July 2010):</p> <table border="1" data-bbox="991 1268 1892 1416"> <tr> <td data-bbox="991 1268 1087 1416">10.</td> <td data-bbox="1087 1268 1797 1416"><i>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</i></td> <td data-bbox="1797 1268 1892 1416">100%</td> </tr> </table>	10.	<i>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</i>	100%
10.	<i>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</i>	100%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><i>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.</i></p>																				
		<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 WRPs for nine individuals found that all nine of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (AB, AM, DE, FDA, HAN, JH, JLS, MF and YBB).</p> <p><b>Other findings:</b> The facility provided the following data:</p> <table border="1" data-bbox="991 862 1824 1162"> <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>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul-Sep 2010</th> </tr> </thead> <tbody> <tr> <td>With identified need</td> <td>N/A</td> <td>144</td> <td>129</td> <td>145</td> </tr> <tr> <td>Receiving service</td> <td>N/A</td> <td>53</td> <td>67</td> <td>90</td> </tr> </tbody> </table> <p>The Mall Service and the Neuropsychology Service plan on increasing the number of Cognitive Remediation Groups as and when staffing and resources (rooms, computers, software programs, etc.) are available.</p> <p><b>Compliance:</b> Substantial.</p>	Individuals in need of Cognitive Remediation Groups during the current and previous three Mall terms						Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010	With identified need	N/A	144	129	145	Receiving service	N/A	53	67	90
Individuals in need of Cognitive Remediation Groups during the current and previous three Mall terms																						
	Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010																		
With identified need	N/A	144	129	145																		
Receiving service	N/A	53	67	90																		

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
C.2.t	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 (February-July 2010):</p> <table border="1" data-bbox="991 748 1890 935"> <tr> <td data-bbox="991 748 1087 935">11.</td> <td data-bbox="1087 748 1795 935"><i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i></td> <td data-bbox="1795 748 1890 935">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 WRPs for six individuals found that three of the WRPs met the elements of this requirement (JH, MLB and YSL) and the remaining three were missing one or more elements or did not satisfy the criteria for this recommendation (AM, JD and RO). There are inconsistencies in the documentation in the Present Status section of RO's WRP. For example, in one paragraph the statement reads "In general the Mall notes from August [the WRP is dated July 10, 2010] indicate Ms. O attends her groups, participates well and is making acceptable progress," and in the paragraph just below it reads "in the</p>	11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i>	98%
11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)</i>	98%			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>WRAP . . . has difficulty grasping concepts and has made minimal progress, in coping skills thru art she attends regularly and interacts, . . . needs multiple prompts to participate . . . is making minimal progress, in the medication and wellness and substance recovery . . . is making minimal progress, in court competency . . .difficulty with memory and attention". The Present Status section of AM's WRP (dated June 14, 2010) states that AM has no barriers to discharge, all discharge criteria were checked off as "met." However, many of the interventions were checked off as being active, the status is listed as "not met", and had target dates for the next review. The discharge criteria for JD (WRP dated June 11, 2010) are not observable and measurable. This creates difficulty in measuring progress to meet objectives. For example, one discharge requirement reads "Continue engagement in core Mall treatment groups (his attendance has improved, but remains under CONREP thresholds)." If the criterion was, and it appears to be, a CONREP requirement (as reviewed by the WRPT and CONREP representative on September 14, 2009), the WRPT should write it in observable and measurable terms so that the individual knows the performance criteria, the team knows how to assess progress, and the providers know when the objective is met.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
C.2.u	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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 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</li> </ul>

Section C: Integrated Therapeutic and Rehabilitation Services Planning

compared to the last period).

**Findings:**

The facility provided the following data:

Individuals in need of WRP Education during the current and previous three Mall terms				
	Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul-Sep 2010
With identified need	370	579	557	345
Receiving service	370	579	557	295

Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (February-July 2010, mean)	
Sessions scheduled	2,661
Sessions held	1,996
% held	75%
Individuals scheduled	295
Individuals attended at least one group per month	237
% attended	80%

As shown in the tables above, MSH had enrolled 86% of the individuals to WRP education groups. Only 80% of those assigned to the groups had attended at least on group per month during this review period. In addition, only 75% of the scheduled groups were held. These data are an improvement from the previous progress report. MSH should continue to address these issues and increase the number of groups offered, the percentage of groups held, and the percentage of attendance.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>Record review of 14 individuals found that 11 individuals were enrolled in WRAP groups (ALS, BTB, DE, FDA, HQN, JL, OLM, PC, RAM, SS and YVB), two were not enrolled in the groups but with a rationale for not enrolling them at this time (AB and AM), and one was not enrolled in any WRP education group or provided any rationale (BMW).</p> <p><b>Compliance:</b> Partial; improved from the previous review.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide data regarding number of individuals in need of this education and number and hours of education provided to meet this need.</li> <li>2. 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> </ol>										
C.2.v	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to provide data (including comparisons with the previous review period) regarding number of:</p> <ol style="list-style-type: none"> <li>a. Individuals in need of Medication Education Groups;</li> <li>b. Number of individuals scheduled for Medication Education Groups;</li> <li>c. Number of Medication Education Groups offered; and</li> <li>d. Hours (per week) of Medication Education Groups.</li> </ol> <p><b>Findings:</b> MSH presented the following data on the numbers of individuals in need of Medication Education groups and receiving the service:</p> <table border="1" data-bbox="991 1300 1885 1412"> <thead> <tr> <th></th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> <th>Apr-Jun 2010</th> <th>Jul 2010</th> </tr> </thead> <tbody> <tr> <td>Number of individuals</td> <td>321</td> <td>364</td> <td>362</td> <td>438</td> </tr> </tbody> </table>		Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul 2010	Number of individuals	321	364	362	438
	Oct-Dec 2009	Jan-Mar 2010	Apr-Jun 2010	Jul 2010								
Number of individuals	321	364	362	438								

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<table border="1"> <tr> <td>needing service</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Number of individuals receiving service</td> <td>321</td> <td>364</td> <td>362</td> <td>438</td> </tr> </table>	needing service					Number of individuals receiving service	321	364	362	438				
needing service																
Number of individuals receiving service	321	364	362	438												
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>The facility's data for some quarters were inconsistent with the data presented during the last review; this is believed to be an inadvertent transposition.</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 consistency of data across reviews.</li> </ol> <p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility did not present non-adherence data. The facility also did not present data (as it did during the previous period) on the reasons for non-adherence and the targeted interventions to address non-adherence.</p> <p>MSH presented data, as shown in the tables below, on six individuals who were enrolled in NRT to address their non-adherence. The number served using NRT has increased from the four served during the previous review period. According to MSH, the facility has three NRT trained staff to provide NRT services.</p>														

Section C: Integrated Therapeutic and Rehabilitation Services Planning

Individual	Hope Scale Scores	
	Pre-NRT	With NRT
AL	41	--
CR	36	34
JD	25	Discontinued
MB	35	31
MF	24	29
RM	26	--

  

Individual	Mindfulness Attention Awareness Scale Scores	
	Pre-NRT	With NRT
AL	5.33	--
CR	2.6	3.86
JD	3.5	Discontinued
MB	5.67	2.33
MF	4.8	5.6
RM	5.86	--

  

Individual	URICA (Self-Assessment by the Individuals)	
	Pre-NRT	With NRT
AL	14.8	--
CR	7.1	8.71
JD	8.3	Discontinued
MB	13.14	7.98

Section C: Integrated Therapeutic and Rehabilitation Services Planning

MF	4.4	11.5
RM	6.0	--

Individual	URICA (Staff Assessment)	
	Pre-NRT	With NRT
AL	8.61	--
CR	7.2	6.42
JD	6.3	Discontinued
MB	13.04	8.61
MF	9.3	9.42
RM	N/A	--

As the tables above indicate, pre-post data were available only for three of the six individuals in the treatment group. The overall data summary across measures suggests that two of the individuals benefitted from the services across measures (MF and CR, though CR appears to have a lower score on the URICA staff assessment), and one had not made improvement from NRT (MB).

**Compliance:**

Partial.

**Current recommendations:**

1. Implement a system of trigger notifications and tracking of response by the WRPTs.
2. Provide information to demonstrate that MSH's current program to motivate individuals addresses barriers towards individuals' participation in their WRPs, including Mall groups.
3. Provide data regarding:
  - a) All systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>cognitive behavioral interventions that are provided (with number of providers);</p> <ul style="list-style-type: none"><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>
--	--	--

Section D: Integrated Assessments

D. Integrated Assessments		
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> MSH has maintained substantial compliance with the requirements of Section D.1.</p> <p><b>Summary of Progress on Psychological Assessments:</b> 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.</p> <p><b>Summary of Progress on Nursing Assessments:</b> Although the quality of the Nursing Admission and Integrated Assessments remains exceptional, the facility needs to ensure that assessments are conducted timely and that RNs attend the WRPTs to come into compliance with this section.</p> <p><b>Summary of Progress on Rehabilitation Therapy Assessments:</b> MSH has maintained substantial compliance with all requirements of Section D.4 and should continue to focus on systemic development and improving current practice.</p> <p><b>Summary of Progress on Nutrition Assessments:</b> MSH has maintained substantial compliance with all requirements of Section D.5 and should continue to improve and enhance current practice.</p> <p><b>Summary of Progress on Social History Assessments:</b> MSH continues to maintain substantial compliance to the recommendations in the Social History Assessment section.</p>

Section D: Integrated Assessments

		<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>
--	--	---

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. Bala Gulasekaram, MD, Chief of Psychiatry</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 22 individuals: AD, AJKD, AP, CP, DSH, HEY, HGF, JAS, JC, JR, KMC, LF, LJ, MB, MGS, MP, OC, OH, SACC, SDS, TCC and VMC</li> <li>2. Monthly Psychiatrist Progress Notes for 24 individuals; AF, ARG, BS, BT, CP, CW, DRL, EA, EE, GB, IJC, JCB, JF, JKF, KAT, KS, LB, MM, MO, RD, RM, SH, TO, and WL</li> <li>3. DMH Medical Initial Admission Assessment Audit summary data (February - July 2010)</li> <li>4. DMH Admission Psychiatric Assessment summary data (February - July 2010)</li> <li>5. DMH Integrated Psychiatric Assessment Auditing summary data (February - July 2010)</li> <li>6. DMH Weekly Physician Progress Note Audit summary data (February - July 2010)</li> <li>7. DMH Monthly PPN Auditing summary data (February - July 2010)</li> <li>8. DMH Physician Inter-Unit Transfer Note Audit summary data (February - July 2010)</li> <li>9. Neuropsychiatry lecture training materials on the following two subjects: Tardive Dyskinesia and Seizures</li> </ol>
D.1.a	<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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>

Section D: Integrated Assessments

diagnoses.

**Findings:**

MSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess its compliance for the review period (February-July 2010). The average samples were 62% of admission assessments, 76% 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:

<b>Admission Assessment</b>		
4.	<i>Admission diagnosis is documented</i>	100%

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

<b>Integrated Assessment</b>		
2.b	<i>Statements from the individual are included, if available.</i>	100%
2.d	<i>Includes Diagnosis and medications given at previous facility are included</i>	100%
7.	<i>Includes diagnostic formulation</i>	100%
8.	<i>Includes differential diagnosis</i>	100%
9.	<i>Includes current psychiatric diagnoses</i>	100%

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

<b>Monthly PPN</b>		
3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically appropriate.</i>	98%

Comparative data indicated that MSH has maintained a compliance rate

Section D: Integrated Assessments

		<p>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>
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, March 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> MSH has continued its current practice. The facility's data indicate that 100% of the psychiatrists employed by MSH successfully completed at least three years of psychiatry residency training in a residency program accredited by the Accreditation Counsel for Graduate Medical Education (ACGME). The number of board-certified psychiatrists has remained the same since the last review. The following is an outline of psychiatric positions as reported by MSH:</p>

Section D: Integrated Assessments

		<table border="1" data-bbox="993 228 1724 358"> <tr> <td>FTE positions</td> <td>Jan 2010</td> <td>Jul 2010</td> </tr> <tr> <td>All positions</td> <td>44</td> <td>42</td> </tr> <tr> <td>Positions providing direct care</td> <td>37</td> <td>36</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	Jan 2010	Jul 2010	All positions	44	42	Positions providing direct care	37	36
FTE positions	Jan 2010	Jul 2010									
All positions	44	42									
Positions providing direct care	37	36									
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH continued to implement the process and indicators used in the re-privileging system as of July 2009. As of this tour, 27% of MSH's psychiatrists have been re-privileged using this system.</p> <p><b>Compliance:</b> Substantial, pending receipt of information regarding the number and percentage of psychiatrists re-privileged using this system.</p> <p><b>Current recommendation:</b> Continue current practice.</p>									

Section D: Integrated Assessments

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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Admission Medical Assessment Audit form to assess its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 66% of admissions each month during the review period (February-July 2010). The facility reported 100% compliance 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>Recommendation 2, March 2010:</b> Ensure that the neurological examination of deep tendon reflexes is completed consistently.</p> <p><b>Findings:</b> Same as in D.1.c.i.3</p> <p><b>Other findings:</b> A review of the charts of 10 individuals admitted during the review period (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) found substantial compliance in nine charts and noncompliance in one (KMC). The neurological examination of KMC was incomplete.</p> <p><b>Compliance:</b> Substantial.</p>

Section D: Integrated Assessments

		<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.
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	<p>within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Admission Psychiatric Assessment Audit, MSH assessed its compliance based on an average sample of 62% of admissions each month during the review period (February-July 2010). The facility reported 100% compliance with this requirement. 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. The comparative</p>

Section D: Integrated Assessments

		<p>data are listed, as appropriate.</p> <p><b>Recommendation 2, March 2010:</b> Refine the current template of violence risk assessment to ensure that information is provided to specify the time frames and nature/seriousness of previous aggressive behavior.</p> <p><b>Findings:</b> DMH has implemented this recommendation.</p> <p><b>Other findings:</b> A review of the charts of 10 individuals (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) found substantial compliance in nine charts and partial compliance in one (JAS). The chart of JAS included generic reference to the individual's insight and judgment.</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 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.

Section D: Integrated Assessments

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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Integrated Assessment Psychiatry Section Audit, MSH assessed its compliance based on an average sample of 76% of Integrated Assessments due each month during the review period (February-July 2010). The facility reported 100% compliance with this requirement. 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> A review of the charts of 10 individuals (AD, CP, HEY, JAS, KMC, LF, MB, OH, SDS and TCC) found substantial compliance in all cases. This monitor did not assess the formulation of the individual's strengths as part of the integrated assessment. This area is addressed in Section C.2 as part of the WRPs.</p>

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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.
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.

Section D: Integrated Assessments

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, March 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> During this review period, MSH provided/facilitated an adequate number and range of CME activities. The following table outlines CME activities that addressed neuropsychiatric topics (the facility did not provide data regarding the disciplines of attendees):</p> <table border="1" data-bbox="989 971 1900 1414"> <thead> <tr> <th>Date</th> <th>Title</th> <th>Speaker/affiliations</th> <th>Attendees</th> </tr> </thead> <tbody> <tr> <td>2/10/10</td> <td>Seizures Update</td> <td>Behnam L. Behnam, MD, University of California at Irvine (UCI)</td> <td>34</td> </tr> <tr> <td>2/17/10</td> <td>Neurotransmitters and Their Implication for the treatment of Dementia</td> <td>Gus Alva, MD, UCI</td> <td>36</td> </tr> <tr> <td>4/15/10</td> <td>Parkinson's Disease</td> <td>Behnam L. Behnam, MD</td> <td>30</td> </tr> <tr> <td>5/20/10</td> <td>EPS &amp; Neuroleptic</td> <td>Behnam L. Behnam, MD</td> <td>5</td> </tr> </tbody> </table>	Date	Title	Speaker/affiliations	Attendees	2/10/10	Seizures Update	Behnam L. Behnam, MD, University of California at Irvine (UCI)	34	2/17/10	Neurotransmitters and Their Implication for the treatment of Dementia	Gus Alva, MD, UCI	36	4/15/10	Parkinson's Disease	Behnam L. Behnam, MD	30	5/20/10	EPS & Neuroleptic	Behnam L. Behnam, MD	5
Date	Title	Speaker/affiliations	Attendees																			
2/10/10	Seizures Update	Behnam L. Behnam, MD, University of California at Irvine (UCI)	34																			
2/17/10	Neurotransmitters and Their Implication for the treatment of Dementia	Gus Alva, MD, UCI	36																			
4/15/10	Parkinson's Disease	Behnam L. Behnam, MD	30																			
5/20/10	EPS & Neuroleptic	Behnam L. Behnam, MD	5																			



Section D: Integrated Assessments

		4/27/10	New Anti-Psychotics	Grayden, MD, UCI	22
		5/12/10	Malingering (Case Conference)	M. Beshay, MD, University of California at Los Angeles (UCLA)	31
		5/19/10	Second Generation Antipsychotic Updates	John Tsuang, MD, UCLA, Washington State University	32
		6/9/10	Drug to Drug Interaction (Case Conference)	Behnam L. Behnam, MD	22
		6/23/10	Psychopharmacology updates	Dr. Lawrence Cohen, PharmD, BCPP, FASHP, FCCP	15
		6/30/10	Narrative Restructuring Therapy	Drs. A. Singh and S. Greve, MSH	12
		7/8/10	Management of Schizophrenia	John Derimejian, MD, UCLA	10
		7/27/10	New Antipsychotic Iloperidone	Gerald Maguire, MD, UCI	14
		7/28/10	SNRIs	John Derimejian, MD	7
		<p><b>Recommendation 2, March 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></p> <table border="1"> <thead> <tr> <th>Diagnostic category</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="2">Number of individuals in category regardless of duration</td> </tr> <tr> <td>Rule Out</td> <td>12</td> <td>29</td> </tr> <tr> <td>Deferred</td> <td>11</td> <td>10</td> </tr> <tr> <td>NOS</td> <td>17</td> <td>30</td> </tr> <tr> <td></td> <td colspan="2">Number of individual in category for more than 60 days</td> </tr> <tr> <td>Rule Out</td> <td>11</td> <td>3</td> </tr> <tr> <td>Deferred</td> <td>9</td> <td>7</td> </tr> <tr> <td>NOS</td> <td>16</td> <td>13</td> </tr> </tbody> </table> <p><b>Other findings:</b>  This monitor reviewed the charts of the two individuals who currently received diagnoses listed as NOS for three or more months. The review found substantial compliance in both cases.</p> <table border="1"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>DSH</td> <td>Cognitive Disorder</td> </tr> <tr> <td>HGF</td> <td>Dementia NOS R/O Dementia due to Pituitary Tumor</td> </tr> </tbody> </table> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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.</li> </ol>	Diagnostic category	Previous Period	Current Period		Number of individuals in category regardless of duration		Rule Out	12	29	Deferred	11	10	NOS	17	30		Number of individual in category for more than 60 days		Rule Out	11	3	Deferred	9	7	NOS	16	13	Initials	Diagnosis (NOS)	DSH	Cognitive Disorder	HGF	Dementia NOS R/O Dementia due to Pituitary Tumor
Diagnostic category	Previous Period	Current Period																																	
	Number of individuals in category regardless of duration																																		
Rule Out	12	29																																	
Deferred	11	10																																	
NOS	17	30																																	
	Number of individual in category for more than 60 days																																		
Rule Out	11	3																																	
Deferred	9	7																																	
NOS	16	13																																	
Initials	Diagnosis (NOS)																																		
DSH	Cognitive Disorder																																		
HGF	Dementia NOS R/O Dementia due to Pituitary Tumor																																		

Section D: Integrated Assessments

		<p>2. 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>
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, March 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 recommendations:</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, March 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 recommendations:</b> Same as in D.1.d.i.</p>

Section D: Integrated Assessments

<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, March 2010:</b> Continue to provide information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p> <p><b>Findings:</b> MSH reportedly had no individuals in this category.</p> <p><b>Other findings:</b> Chart reviews by this monitor found no evidence of any individual in this category.</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 this reporting 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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Weekly Physician Progress Note (PPN) Audit, MSH assessed its compliance based on an average sample of 39% of individuals with length of stay less than 60 days during the review period (February-July 2010):</p>

Section D: Integrated Assessments

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 80%;"><i>The reassessments are completed weekly for the first 60 days on the admission units:</i></td> <td style="width: 15%; text-align: center;">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>MSH also used the DMH Monthly PPN Audit to assess compliance. The average sample was 23% of individuals who had been hospitalized for 90 days or more. The mean compliance rate for this requirement for this review period was 100%. 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 10 individuals who were admitted during this reporting period. The review focused on the timeliness of the notes and found compliance in all cases regarding the weekly notes for individuals hospitalized fewer than 60 days and monthly notes for individuals hospitalized for 90 or more days.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>	99%
1.	<i>The reassessments are completed weekly for the first 60 days on the admission units:</i>	99%			
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 recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH Monthly PPN Audit to assess compliance, based on an</p>			

Section D: Integrated Assessments

		<p>average sample of 23% of individuals who had been hospitalized for 90 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>Other findings:</b>  This monitor reviewed Monthly Psychiatrist Progress Notes for 24 individuals (AF, ARG, BS, BT, CP, CW, DRL, EA, EE, GB, IJC, JCB, JF, JKF, KAT, KS, LB, MM, MO, RD, RM, SH, TO and WL). These notes were selected from the work of different providers. Overall, the reviews found that the staff psychiatrists have maintained adequate practice in the documentation of psychiatric reassessments during this review period. However, it is worth mentioning that in too many notes, there was a pattern of overly redundant and unnecessary documentation of irrelevant clinical data. This practice indicates the need for streamlining of the current template to ensure that documentation is focused only on relevant clinical data (see comments in the introduction regarding this matter).</p> <p>This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during the review period (AP, JR, MP, OC, SACC and VMC). The review focused on the utilization of PRN/Stat medications (as documented in the orders and progress notes). This review is also relevant to the requirements in D.1.f.vi and F.1.b. The review found general evidence of improved 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 individual's progress or lack thereof (OC and VMC);</li> <li>2. Face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications (OC); and</li> <li>3. Adjustment of regular medication regimen and of PRN/Stat medication regimen based on individual's progress or lack thereof</li> </ol>
--	--	---

Section D: Integrated Assessments

		<p>(OC).</p> <p>However, there was evidence of delay in initiating a referral for a PBS plan in the chart of OC and no face-face assessment (within 24 hours of the administration of Stat medication) was documented in the chart of VMC. One individual (MP) received PRN/Stat medications on repeated occasions and required seclusion/restraints on at least 15 occasions (from January 4 to February 28, 2010) while continuously being ordered treatment with fluoxetine. However, there was documented justification for the rationale of ordering this medication.</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. Address and correct this monitor's findings of some deficiencies regarding the use of PRN/Stat medications.</li> <li>3. Streamline current templates for documentation of psychiatric reassessments to improve attention to relevant clinical data.</li> </ol>
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;	92%. 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;	92%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls)	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.

Section D: Integrated Assessments

	including appropriate and timely monitoring of individuals and interventions to reduce risks;	
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;	98%. 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 psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	100%. Note that findings by this monitor in D.1.f do not corroborate this rate. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.f.vii	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.	100%. Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and	<b>Current findings on previous recommendations:</b>

Section D: Integrated Assessments

psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.

**Recommendation 1, March 2010:**

Continue to monitor this requirement.

**Findings:**

MSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 23% of the individuals who experienced inter-unit transfer per month during the review period (February-July 2010):

	<i>Overall compliance rate</i>	100%
1.	<i>Psychiatric course of hospitalization,</i>	100%
2.	<i>Medical course of hospitalization,</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%

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

**Recommendation 2, March 2010:**

Refine the template for the transfer assessments to include a section regarding the plan of care.

**Findings:**

MSH has proposed a refinement of the template to ensure documentation of the plan of care.

**Other findings:**

This monitor reviewed the charts of six individuals who experienced inter-unit transfers during the review period. The following outlines the reviews:

Section D: Integrated Assessments

		<table border="1" data-bbox="991 228 1476 500"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>AJKD</td> <td>6/2/10</td> </tr> <tr> <td>CP</td> <td>6/15/10</td> </tr> <tr> <td>JC</td> <td>7/12/10</td> </tr> <tr> <td>LJ</td> <td>6/7/10</td> </tr> <tr> <td>MGS</td> <td>6/14/10</td> </tr> <tr> <td>SDS</td> <td>8/23/10</td> </tr> </tbody> </table> <p data-bbox="991 540 1906 756">The review found substantial compliance in the charts of CP, LJ, MGS and SDS and partial compliance in the charts of AJKD and JC. There was evidence of generic documentation of current target symptoms in the chart of AJKD and inadequate documentation of the plan of care in the charts of AJKD and JC (and the course of hospitalization in the chart of JC).</p> <p data-bbox="991 800 1140 865"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 911 1325 938"><b>Current recommendations:</b></p> <ol data-bbox="991 948 1871 1052" style="list-style-type: none"> <li>1. Continue to monitor this requirement.</li> <li>2. Address and correct this monitor's findings of some deficiencies in the documentation of the assessments.</li> </ol>	Initials	Date of transfer	AJKD	6/2/10	CP	6/15/10	JC	7/12/10	LJ	6/7/10	MGS	6/14/10	SDS	8/23/10
Initials	Date of transfer															
AJKD	6/2/10															
CP	6/15/10															
JC	7/12/10															
LJ	6/7/10															
MGS	6/14/10															
SDS	8/23/10															

Section D: Integrated Assessments

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	

Section D: Integrated Assessments

	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	

Section D: Integrated Assessments

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	

Section D: Integrated Assessments

	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.	

Section D: Integrated Assessments

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. Cindy Lusch, RN, Acting Nursing Administrator</li> <li>3. Linda Gross, RN, Nursing Coordinator, CNS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH's progress report and data</li> <li>2. MSH's training rosters</li> <li>3. Admission and integrated assessments and WRPs for the following 40 individuals: ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO</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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Nursing Admission Assessment Monitoring Audit, MSH reported a compliance rate of 100% based on a 100% sample of admissions each month during the review period (February-July 2010). Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section D: Integrated Assessments

		<p>A review of Nursing Admission Assessments for 40 individuals (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found that MSH has maintained the exceptional quality of the nursing admission assessments. The assessments reviewed included more information addressing the individual's psychiatric history gathered from available records and all of the presenting condition sections included the opened foci supported by information from the assessments. These findings comport with MSH's data. MSH needs to continue the mentoring by the Nurse Practitioner regarding nursing admission assessments to ensure that these assessments continue to be thorough and comprehensive nursing documents.</p> <p>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 (February-July 2010):</p> <table border="1" data-bbox="991 894 1892 1044"> <tr> <td data-bbox="991 894 1087 1044">1.</td> <td data-bbox="1087 894 1795 1044"><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 894 1892 1044">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 Integrated Nursing Assessments for 40 individuals (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found that MSH has also maintained the quality of the Integrated Nursing Assessments since the last review. The Integrated Assessments reviewed included updated</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>	99%
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>	99%			

Section D: Integrated Assessments

		<p>clinical information rather than just repeated information that was contained in the Admission Nursing Assessment. These findings comport with MSH's data.</p> <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" data-bbox="991 527 1890 824"> <tr> <td data-bbox="991 527 1087 824">2.</td> <td data-bbox="1087 527 1795 824"><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 data-bbox="1795 527 1890 824">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><u>Integrated Assessments</u></p> <table border="1" data-bbox="991 1047 1890 1230"> <tr> <td data-bbox="991 1047 1087 1230">2.</td> <td data-bbox="1087 1047 1795 1230"><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 data-bbox="1795 1047 1890 1230">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>	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>	99%	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>	99%
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>	99%						
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>	99%						

Section D: Integrated Assessments

D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 266 1892 305"> <tr> <td data-bbox="991 266 1087 305">3.</td> <td data-bbox="1087 266 1793 305"><i>Vital signs</i></td> <td data-bbox="1793 266 1892 305">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" data-bbox="991 526 1892 565"> <tr> <td data-bbox="991 526 1087 565">3.</td> <td data-bbox="1087 526 1793 565"><i>Vital signs</i></td> <td data-bbox="1793 526 1892 565">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>	3.	<i>Vital signs</i>	100%	3.	<i>Vital signs</i>	99%
3.	<i>Vital signs</i>	100%						
3.	<i>Vital signs</i>	99%						
D.3.a.iv	allergies;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 786 1892 824"> <tr> <td data-bbox="991 786 1087 824">4.</td> <td data-bbox="1087 786 1793 824"><i>Allergies</i></td> <td data-bbox="1793 786 1892 824">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" data-bbox="991 1045 1892 1084"> <tr> <td data-bbox="991 1045 1087 1084">4.</td> <td data-bbox="1087 1045 1793 1084"><i>Allergies</i></td> <td data-bbox="1793 1045 1892 1084">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>	4.	<i>Allergies</i>	100%	4.	<i>Allergies</i>	99%
4.	<i>Allergies</i>	100%						
4.	<i>Allergies</i>	99%						
D.3.a.v	pain;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 1313 1892 1352"> <tr> <td data-bbox="991 1313 1087 1352">5.</td> <td data-bbox="1087 1313 1793 1352"><i>Pain</i></td> <td data-bbox="1793 1313 1892 1352">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate</p>	5.	<i>Pain</i>	99%			
5.	<i>Pain</i>	99%						

Section D: Integrated Assessments

		<p>of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>5.</td> <td><i>Pain</i></td> <td>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>	5.	<i>Pain</i>	99%			
5.	<i>Pain</i>	99%						
D.3.a.vi	use of assistive devices;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i></td> <td>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><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>6.</td> <td><i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i></td> <td>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>	6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	99%	6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	99%
6.	<i>Use of assistive devices: The functional assessment and assistive devices section is complete, or the "no concerns", "no condition" or "none" boxes is checked.</i>	99%						
6.	<i>The update assistive devices use or need section is complete, or the "no problems noted" box is checked.</i>	99%						
D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</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>	7.	<i>Activities of daily living</i>	100%			
7.	<i>Activities of daily living</i>	100%						

Section D: Integrated Assessments

		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 266 1887 305"> <tr> <td data-bbox="993 266 1087 305">7.</td> <td data-bbox="1087 266 1793 305"><i>Activities of daily living</i></td> <td data-bbox="1793 266 1887 305">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>	7.	<i>Activities of daily living</i>	99%			
7.	<i>Activities of daily living</i>	99%						
D.3.a.viii	<p>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>	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 526 1887 643"> <tr> <td data-bbox="993 526 1087 643">8.</td> <td data-bbox="1087 526 1793 643"><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 526 1887 643">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" data-bbox="993 863 1887 980"> <tr> <td data-bbox="993 863 1087 980">8.</td> <td data-bbox="1087 863 1793 980"><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td data-bbox="1793 863 1887 980">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>	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	99%
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	100%						
8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	99%						
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 1200 1887 1239"> <tr> <td data-bbox="993 1200 1087 1239">9.</td> <td data-bbox="1087 1200 1793 1239"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1793 1200 1887 1239">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>	9.	<i>Conditions needing immediate nursing interventions</i>	100%			
9.	<i>Conditions needing immediate nursing interventions</i>	100%						

Section D: Integrated Assessments

		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 264 1887 305"> <tr> <td data-bbox="993 264 1087 305">9.</td> <td data-bbox="1087 264 1795 305"><i>Conditions needing immediate nursing interventions</i></td> <td data-bbox="1795 264 1887 305">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>	9.	<i>Conditions needing immediate nursing interventions</i>	99%
9.	<i>Conditions needing immediate nursing interventions</i>	99%			
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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>			
D.3.c	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH training rosters verified that all 22 RNs who were required to complete competency-based training regarding Nursing Assessments completed and passed the training. In addition, all 196 nurses employed at MSH have current licenses.</p>			

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
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, March 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 (February-July 2010):</p> <table border="1" data-bbox="991 971 1890 1047"> <tr> <td>10.</td> <td><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</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>A review of Nursing Admission Assessments for 40 individuals (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found that all were timely completed.</p>	10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	100%
10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	100%			

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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% sample of admissions each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 784 1890 933"> <tr> <td data-bbox="991 784 1087 933">10.</td> <td data-bbox="1087 784 1795 933"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1795 784 1890 933">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 Integrated Nursing Assessments for 40 individuals (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found that they were completed timely and were of consistent quality. The instructions for the assessment should be updated to reflect the seven-day time frame for completion.</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	99%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	99%			

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Update the instructions for the assessment to reflect the seven-day time frame (rather than the fourth or fifth day after admission).</li> <li>2. Continue to monitor this requirement.</li> </ol>									
D.3.d.iii	<p>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 shall be the annual review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 21% of WRPCs observed each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 857 1917 1013"> <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>98%</td> <td>99%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>92%</td> <td>91%</td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (ACR, AM, ARM, ASG, BNM, CBB, CC, CED, CH, CKD, CM, CMP, DLW, DRT, EAH, EE, GAM, JAS, JE, JI, JJZ, JT, MAA, NE, OD, OEV, PL, PMS, RB, RC, RP, RRV, RSP, RTG, SAS, SH, SS, VCH, VX and WO) found documentation of RN and PT attendance at the WRPC in 33 and 24 WRPs, respectively. However, four of the 40 signature pages for the WRPs did not include a name or signature space for a PT. Consequently, there was no way to determine if a PT had attended these WRPTs.</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	98%	99%	<i>Psychiatric Technician attendance at WRPC</i>	92%	91%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	98%	99%									
<i>Psychiatric Technician attendance at WRPC</i>	92%	91%									

Section D: Integrated Assessments

		<p><b>Compliance:</b> Partial, based on lack of RN attendance at WRPCs.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Ensure that an RN attends the WRPCs for presentation of nursing assessment.</li><li>2. Ensure the attendance of PTs is documented in the WRPCs.</li><li>3. Continue to monitor this requirement.</li></ol>
--	--	--

4. Rehabilitation Therapy Assessments		
		<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. Andrea Ciota, Acting Rehabilitation Therapy Chief</li> <li>2. Beth Chapman, Physical Therapist</li> <li>3. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>4. Kim Corrick, Occupational Therapist</li> <li>5. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>6. Rebecca McClary, Acting Supervising Rehabilitation Therapist</li> <li>7. Ricardo Jurado, Speech Therapist</li> <li>8. Ruth Flores, Supervisor of Vocational Services</li> <li>9. Terez Henson, Supervising Rehabilitation Therapist</li> <li>10. Troy Zelones, Physical 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 February-July 2010</li> <li>2. Records of the following 11 individuals who had IA:RTS assessments from February-July 2010: AD, AP, CLH, GAP, HCA, HCA, JL, JS, KL, NH and VF</li> <li>3. List of individuals who had Occupational Therapy assessments from February-July 2010</li> <li>4. Records of the following six individuals who had Occupational Therapy assessments from February-July 2010: AE, FR, JS, NK, SCG and TG</li> <li>5. List of individuals who had Physical Therapy assessments from February-July 2010</li> <li>6. Records of the following five individuals who had Physical Therapy assessments from February-July 2010: FR, JI, GB, OEV, DGB</li> <li>7. List of individuals who had Speech Therapy assessments from February-July 2010</li> <li>8. Records of the following individual who had Speech Therapy assessment from February-July 2010: CC</li> </ol>

Section D: Integrated Assessments

		<ol style="list-style-type: none"> <li>9. List of individuals who had Vocational Rehabilitation assessments from February-July 2010</li> <li>10. Records of the following six individuals who had Vocational Rehabilitation assessments from February-July 2010: JHM, JR, MKC, PL, SH and WNM</li> <li>11. List of individuals who had CIPRTA assessments from February-July 2010</li> <li>12. Records of the following two individuals who had CIPRTA assessments from February-July 2010: LG and MLC</li> <li>13. Vocational Services Timeliness Plan</li> <li>14. POST Services referral draft</li> <li>15. Data Consistency Plan</li> <li>16. CIPRTA Plan Process</li> </ol> <p><u>Observed:</u> RIAT (Rehabilitation Therapy Integrated Assessment Team) clinic</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, March 2010:</b> Revise and update current protocols as needed according to systemic changes and evolving standards of practice.</p> <p><b>Findings:</b> Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice, as well as streamlined to promote optimal clinical utility.</p> <p>The RIAT assessment clinic was observed and it was noted that the clinic was conducted in an interdisciplinary format and included clinical observation methods that were in line with the RT Integrated</p>

Section D: Integrated Assessments

		<p>Assessment protocol.</p> <p>In order to ensure that individuals are referred for appropriate POST assessments and services, the POST department has provided education regarding these focused assessments during NEO training. However, it seems that existing treatment team members would benefit from a practical reference in order to ensure that individuals throughout the facility are referred for appropriate and timely POST assessments. The facility has developed a draft of a POST referral form that would serve this purpose.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</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>
D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> During the maintenance period, develop and implement a plan to ensure that past due Vocational focused assessments are completed and new assessments are completed in a timely manner.</p> <p><b>Findings:</b> The facility developed and implemented the Vocational Services Timeliness Plan to address the issue of timeliness of new referrals for Vocational Rehabilitation focused assessments as well as past due assessments. Plan strategies for improving timeliness of VRAT assessments included providing reminder notices for clinicians, requiring clinicians to complete pending assessments prior to scheduled time off,</p>

		<p>requiring clinicians to complete pending assessments immediately following unscheduled leave, and counseling and mentoring clinicians to encourage timely assessment completion.</p> <p><b>Recommendation 2, March 2010:</b>                  During the maintenance period, develop a process to ensure consistency between number of individuals requiring focused assessments reported on databases and on self assessment data reports.</p> <p><b>Findings:</b>                  The Data Consistency Plan was developed in March in order to address this recommendation. The POST referral log, assessment log, and direct service logs were revised and integrated into one tracking system per discipline on March 18, 2010 to prevent errors due to disparate data sources. The Vocational Service referral log was revised to eliminate individuals who were discharged, who were not eligible to work, and individuals who were requesting IT assignment changes and therefore did not require a VRAT assessment. In addition, the plan requires the POST supervisor to meet with the Rehab Chief monthly to review the accuracy of databases and PLATO data.</p> <p>Upon review of databases and comparison with self-assessment data, it appeared that the data found in the database for physical therapy assessments and the self-assessment progress report were inconsistent. Review of these databases found that screens and assessments performed in response to referrals were listed as well as individuals for whom referrals were made but assessments were not completed due to refusals. The current format should be revised to improve clarity, consistency and utility and facilitate the accurate tracking of referrals for and completion of focused assessments.</p> <p><b>Recommendation 3, March 2010:</b>                  Continue to enhance current practice.</p>
--	--	--

Section D: Integrated Assessments

		<p><b>Findings:</b>            Using the DMH Integrated Assessment: Rehabilitation Therapy Section Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Assessments: Rehabilitation Therapy Section due each month for the review period February-July 2010 (total of 250 out of 251; one individual was discharged within five days of admission):</p> <table border="1" data-bbox="991 524 1890 748"> <tr> <td data-bbox="991 524 1087 748">1.</td> <td data-bbox="1087 524 1776 748"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i></td> <td data-bbox="1776 524 1890 748">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 11 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 based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2010 (total of 10):</p> <table border="1" data-bbox="991 1192 1890 1382"> <tr> <td data-bbox="991 1192 1087 1382">1.</td> <td data-bbox="1087 1192 1776 1382"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1776 1192 1890 1382">100%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i>	100%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i>	100%						
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%						

Section D: Integrated Assessments

		<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 six individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance. However, the Occupational Therapy focused assessment database stated that no OT was on staff for the month of July, and listed no referrals for assessment that month. It was unclear whether there were no referrals for that month, or no referrals were answered due to the lack of an available clinician.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2010 (total of 46):</p> <table border="1" data-bbox="991 782 1890 971"> <tr> <td data-bbox="991 782 1087 971">1.</td> <td data-bbox="1087 782 1776 971"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1776 782 1890 971">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 five 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 based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2010 (total of one):</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%			

Section D: Integrated Assessments

		<table border="1"> <tr> <td data-bbox="976 186 1087 415">1.</td> <td data-bbox="1087 186 1776 415"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1776 186 1923 415">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>Only one Speech Therapy focused assessment was performed during the review period, and it was noted during record review that some individuals who would have benefitted from speech therapy assessment received screens. The Speech Therapy assessment log indicated that 35 referrals were made for speech therapy assessment, though screens were completed for these individuals. The facility reported that this was due to limited staffing of only one part-time speech therapist for the review period. The facility reported that the speech therapist has since been hired on a full-time basis, which will allow for the completion of more comprehensive focused assessments, rather than screens, when clinically indicated.</p> <p>A review of the record of one individual to assess compliance of Speech Therapy Focused Assessment with timeliness found the record in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 53% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2010 (total of 40 out of 75):</p> <table border="1"> <tr> <td data-bbox="976 1373 1087 1416">1.</td> <td data-bbox="1087 1373 1776 1416"><i>Each State hospital shall ensure that each individual</i></td> <td data-bbox="1776 1373 1923 1416">94%</td> </tr> </table>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%	1.	<i>Each State hospital shall ensure that each individual</i>	94%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%						
1.	<i>Each State hospital shall ensure that each individual</i>	94%						

Section D: Integrated Assessments

		<table border="1" data-bbox="991 188 1793 342"> <tr> <td data-bbox="991 188 1087 342"></td> <td data-bbox="1087 188 1793 342"> <i>served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i> </td> <td data-bbox="1793 188 1890 342"></td> </tr> </table> <p data-bbox="991 383 1877 451">Comparative data indicated improvement in compliance from 66% in the previous review period.</p> <p data-bbox="991 496 1892 634">A review of the records of six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found four records in compliance (JHM, PL, SH and WNM) and two records not in compliance (JR and MKC).</p> <p data-bbox="991 680 1860 857">Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period February-July 2010 (total of two):</p> <table border="1" data-bbox="991 898 1887 1084"> <tr> <td data-bbox="991 898 1087 1084">1.</td> <td data-bbox="1087 898 1793 1084"> <i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i> </td> <td data-bbox="1793 898 1890 1084">100%</td> </tr> </table> <p data-bbox="991 1130 1892 1198">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1243 1871 1312">A review of the records of two individuals to assess compliance of CIPRTA assessments with timeliness found both records in compliance.</p> <p data-bbox="991 1357 1142 1414"><b>Compliance:</b> Substantial.</p>		<i>served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>		1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
	<i>served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>							
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%						

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue efforts to improve and enhance current system and practice.</p>			
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> During the maintenance period, continue to develop a process to ensure that all individuals who would benefit from a CIPRTA focused assessment receive this service.</p> <p><b>Findings:</b> The facility developed a plan to provide education regarding the CIPRTA during meetings and scheduled training for new employees. As discussed in cell D.4.a, implementation of the POST referral form may provide a practical tool to assist treatment teams in generating a CIPRTA referral when clinically appropriate.</p> <p><b>Recommendation 2, March 2010:</b> Continue efforts to improve and enhance compliance.</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 Assessments: Rehabilitation Therapy Section due each month for the review period February-July 2010 (total of 250 out of 251; one individual was discharged within five days of admission):</p> <table border="1" data-bbox="991 1263 1890 1341"> <tr> <td data-bbox="991 1263 1087 1341">2.</td> <td data-bbox="1087 1263 1776 1341"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1776 1263 1890 1341">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%			

Section D: Integrated Assessments

		<p>least 90% from the previous review period.</p> <p>A review of the records of 11 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 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2010 (total of 10):</p> <table border="1" data-bbox="991 597 1890 673"> <tr> <td data-bbox="991 597 1087 673">2.</td> <td data-bbox="1087 597 1774 673"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1774 597 1890 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 the records of six 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 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2010 (total of 46):</p> <table border="1" data-bbox="991 1156 1890 1232"> <tr> <td data-bbox="991 1156 1087 1232">2.</td> <td data-bbox="1087 1156 1774 1232"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1774 1156 1890 1232">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 five individuals to assess compliance of</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						

Section D: Integrated Assessments

		<p>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 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2010 (total of one):</p> <table border="1" data-bbox="991 487 1890 565"> <tr> <td data-bbox="991 487 1087 565">2.</td> <td data-bbox="1087 487 1774 565"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1774 487 1890 565">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 record of one individual to assess compliance of Speech Therapy Focused Assessment with D.4.b.i criteria found the record 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 53% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2010 (total of 40 out of 75):</p> <table border="1" data-bbox="991 1084 1890 1162"> <tr> <td data-bbox="991 1084 1087 1162">2.</td> <td data-bbox="1087 1084 1774 1162"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1774 1084 1890 1162">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 six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						

Section D: Integrated Assessments

		<p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, MSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period February-July 2010 (total of two):</p> <table border="1" data-bbox="991 414 1892 490"> <tr> <td data-bbox="991 414 1087 490">2.</td> <td data-bbox="1087 414 1776 490"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1776 414 1892 490">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 two individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found both records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%			
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, March 2010:</b> Continue efforts to improve and enhance compliance.</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 Assessments: Rehabilitation Therapy Section due each month for the review period February-July 2010 (total of 250 out of 251; one individual was discharged within five</p>			

Section D: Integrated Assessments

		<p>days of admission):</p> <table border="1" data-bbox="991 266 1887 417"> <tr> <td data-bbox="991 266 1087 339">3.</td> <td data-bbox="1087 266 1776 339"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 266 1887 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 1887 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 11 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 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2010 (total of 10):</p> <table border="1" data-bbox="991 898 1887 1049"> <tr> <td data-bbox="991 898 1087 971">3.</td> <td data-bbox="1087 898 1776 971"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 898 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1049">4.</td> <td data-bbox="1087 971 1776 1049"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 971 1887 1049">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 six 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</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%
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%												

Section D: Integrated Assessments

		<p>sample of 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2010 (total of 46):</p> <table border="1" data-bbox="991 305 1890 454"> <tr> <td data-bbox="991 305 1087 378">3.</td> <td data-bbox="1087 305 1776 378"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 305 1890 378">100%</td> </tr> <tr> <td data-bbox="991 378 1087 454">4.</td> <td data-bbox="1087 378 1776 454"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 378 1890 454">99%</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 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 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2010 (total of one):</p> <table border="1" data-bbox="991 933 1890 1083"> <tr> <td data-bbox="991 933 1087 1006">3.</td> <td data-bbox="1087 933 1776 1006"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1776 933 1890 1006">100%</td> </tr> <tr> <td data-bbox="991 1006 1087 1083">4.</td> <td data-bbox="1087 1006 1776 1083"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1776 1006 1890 1083">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 Speech Therapy Focused Assessment with D.4.b.ii criteria found the record in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring</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>	99%	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>	99%												
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%												

Section D: Integrated Assessments

		<p>Tool, MSH assessed its compliance with D.4.b.ii criteria based on an average sample of 53% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2010 (total of 40 out of 75):</p> <table border="1" data-bbox="991 375 1890 527"> <tr> <td data-bbox="991 375 1087 451">3.</td> <td data-bbox="1087 375 1774 451"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 375 1890 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 527">4.</td> <td data-bbox="1087 451 1774 527"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1774 451 1890 527">97%</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 six 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 February-July 2010 (total of two):</p> <table border="1" data-bbox="991 1008 1890 1161"> <tr> <td data-bbox="991 1008 1087 1084">3.</td> <td data-bbox="1087 1008 1774 1084"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1774 1008 1890 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1087 1161">4.</td> <td data-bbox="1087 1084 1774 1161"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1774 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 for both items.</p> <p>A review of the records of two individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found both records 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>	97%	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>	97%												
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%												

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</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>									
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, March 2010:</b> Continue efforts to improve and enhance compliance.</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 Assessments: Rehabilitation Therapy Section due each month for the review period February-July 2010 (total of 250 out of 251; one individual was discharged within five days of admission):</p> <table border="1" data-bbox="991 1042 1887 1159"> <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 11 individuals to assess compliance of IA:RTS assessments with D.4.b.iii criteria found all records in substantial compliance.</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%									

Section D: Integrated Assessments

		<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 100% of Occupational Therapy Focused Assessments due each month for the review period February-July 2010 (total of 10):</p> <table border="1" data-bbox="991 414 1890 529"> <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 six 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 100% of Physical Therapy Focused Assessments due each month for the review period February-July 2010 (total of 46):</p> <table border="1" data-bbox="991 1011 1890 1127"> <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>97%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>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 three items.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</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>	97%	7.	<i>Motivation for engaging in wellness activities.</i>	99%
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>	97%																		
7.	<i>Motivation for engaging in wellness activities.</i>	99%																		

Section D: Integrated Assessments

		<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 100% of Speech Therapy Focused Assessments due each month for the review period February-July 2010 (total of one):</p> <table border="1" data-bbox="991 375 1890 492"> <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 Speech Therapy Focused Assessment with D.4.b.iii criteria found the record 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 53% of Vocational Rehabilitation Focused Assessments due each month for the review period February-July 2010 (total of 40 out of 75):</p> <table border="1" data-bbox="991 1008 1890 1125"> <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>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 six individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</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>	98%
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>	98%																		

Section D: Integrated Assessments

		<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 each month for the review period February-July 2010 (total of two):</p> <table border="1" data-bbox="993 375 1887 492"> <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 two individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found both records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</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	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue efforts to improve and enhance compliance.</p> <p><b>Findings:</b> The facility reported that one new RT was hired during the review period and was trained to competency on assessment training materials. This was verified by review of training record and competency-based test.</p>									

Section D: Integrated Assessments

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</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. Chris Marshall, Director of Nutrition Services</li> <li>2. Denise Manos, Assistant Director of Nutrition Services</li> <li>3. Mary Ramirez, Assistant Director of Nutrition Services</li> <li>4. Portia Salvacion, Assistant Director of Nutrition Services</li> <li>5. Virginia A. Tovar, Assistant Director of Nutrition Services</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Nutrition Care Monitoring audit data for February-July 2010 for each assessment type</li> <li>2. Lists of individuals with Nutrition Care Assessments due from February-July 2010 for each assessment type</li> <li>3. Records of the following three individuals with type D.5.a assessments from February-July 2010: JK, TG and TP</li> <li>4. Records of the following three individuals with type D.5.c assessments from February-July 2010: CLH, CP and GL</li> <li>5. Records of the following two individuals with type D.5.d assessments from February-July 2010: NR and RSP</li> <li>6. Records of the following five individuals with type D.5.e assessments from February-July 2010: AN, EN, FR, MB and SLF</li> <li>7. Records of the following five individuals with type D.5.g assessments from February-July 2010: ASG, GAA, HI, JB, and TLD</li> <li>8. Records of the following five individuals with type D.5.i assessments from February-July 2010: JM, MW, MWK, RA and RB</li> <li>9. Records of the following six individuals with type D.5.j.i assessments from February-July 2010: BAM, HF, MG, OD, ST and WDT</li> <li>10. Records of the following seven individuals with type D.5.j.ii assessments from February-July 2010: CC, HL, KD, MSN, RS-1, RS-2 and SNG</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, March 2010:</b> Continue 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 February-July 2010 (total of 20):</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>96%</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>	96%	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%
1.	<i>Assessment is completed on time per policy</i>	96%																																							
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%																																							

Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1902 423"> <tr> <td data-bbox="993 191 1087 269">14.</td> <td data-bbox="1087 191 1776 269"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1776 191 1902 269">100%</td> </tr> <tr> <td data-bbox="993 269 1087 310">15.</td> <td data-bbox="1087 269 1776 310"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1776 269 1902 310">100%</td> </tr> <tr> <td data-bbox="993 310 1087 350">16.</td> <td data-bbox="1087 310 1776 350"><i>Assessment is concise</i></td> <td data-bbox="1776 310 1902 350">100%</td> </tr> <tr> <td data-bbox="993 350 1087 391">17.</td> <td data-bbox="1087 350 1776 391"><i>Assessment is legible</i></td> <td data-bbox="1776 350 1902 391">100%</td> </tr> <tr> <td data-bbox="993 391 1087 423">18.</td> <td data-bbox="1087 391 1776 423"><i>Each page of the assessment is signed</i></td> <td data-bbox="1776 391 1902 423">100%</td> </tr> </table> <p data-bbox="993 464 1902 532">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="993 573 1902 641">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 data-bbox="993 682 1140 750"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 790 1457 859"><b>Current recommendation:</b> Continue to enhance current practice.</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%
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%															
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="993 1097 1591 1130"><b>Current findings on previous recommendations:</b></p> <p data-bbox="993 1170 1388 1239"><b>Recommendation, March 2010:</b> Continue current practice.</p> <p data-bbox="993 1279 1902 1421"><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 February-July 2010</p>															

Section D: Integrated Assessments

		(total of two):																																																						
		<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>N/A</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>N/A</td> </tr> <tr> <td>15.</td> <td><i>Assessment utilizes approved abbreviations</i></td> <td>N/A</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>	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>	N/A	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>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	N/A	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%
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>	N/A																																																						
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>	N/A																																																						
15.	<i>Assessment utilizes approved abbreviations</i>	N/A																																																						
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%																																																						
		Comparative data indicated that MSH maintained a compliance rate of at																																																						

Section D: Integrated Assessments

		<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.c criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</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, March 2010:</b> Continue 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.d assessments due each month for the review period February-July 2010 (total of 84):</p> <table border="1" data-bbox="991 1042 1887 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> </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%
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%																		

Section D: Integrated Assessments

		<table border="1"> <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>	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%	<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 two individuals to assess compliance with Nutrition type D.5.d criteria found both records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</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%																																					
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%																																					

Section D: Integrated Assessments

D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue 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.e assessments due each month for the review period February-July 2010 (total of 98):</p> <table border="1" data-bbox="989 597 1887 1424"> <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%
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%																																							

Section D: Integrated Assessments

		<table border="1"> <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 five individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</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%
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%															
D.5.f	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue 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.f assessments due each month for the review period February-July 2010 (total of two):</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</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</i>	100%						
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</i>	100%															

Section D: Integrated Assessments

			<i>accurately addressed</i>	
		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>	N/A
		14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
		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%
		<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>Records for both completed Nutrition type D.5.f were requested but were not available for review.</p>		

Section D: Integrated Assessments

		<p><b>Compliance:</b> Unable to determine</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>																											
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue 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 February-July 2010 (total of 60):</p> <table border="1" data-bbox="989 857 1892 1424"> <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> </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%
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%																											

Section D: Integrated Assessments

		<table border="1"> <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 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.g criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>	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%
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%																											
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its</p>																											

Section D: Integrated Assessments

		<p>compliance based on an average sample of 66% of Nutrition assessments (all types) due each month of the review period February-July 2010 (935 out of 1413). The facility reports that a weighted mean of 100% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p> <p>A review of the records of 37 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with D.5.h.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 52% of Nutrition Type D.5.i assessments due each month for the review period February-July 2010 (total of 473 out of 909):</p> <table border="1" data-bbox="991 1192 1892 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>98%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>98%</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>99%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	98%	2.	<i>All required subjective concerns are addressed</i>	98%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	99%
1.	<i>Assessment is completed on time per policy</i>	98%												
2.	<i>All required subjective concerns are addressed</i>	98%												
3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%												
4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	99%												

Section D: Integrated Assessments

		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%
<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.i criteria found all records in substantial compliance.</p> <p><b>Compliance:</b> Substantial.</p>				

Section D: Integrated Assessments

		<p><b>Current recommendation:</b> Continue to enhance current practice.</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, March 2010:</b> Continue 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 February-July 2010 (total of 27):</p> <table border="1" data-bbox="993 711 1892 1427"> <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>96%</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>96%</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>96%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	96%	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>	96%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and</i>	96%
1.	<i>Assessment is completed on time per policy</i>	100%																																				
2.	<i>All required subjective concerns are addressed</i>	96%																																				
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>	96%																																				
11.	<i>Recommendations are appropriate and complete</i>	100%																																				
12.	<i>NST is correctly assigned to reflect acuity level and</i>	96%																																				

Section D: Integrated Assessments

		<table border="1" data-bbox="991 191 1896 535"> <tr> <td></td> <td><i>date of next review. Include NST in comment</i></td> <td></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 seven 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 enhance current practice.</p>		<i>date of next review. Include NST in comment</i>		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%
	<i>date of next review. Include NST in comment</i>																						
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%																					
D.5.j.ii	Every individual will be assessed annually.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nutrition Care Monitoring Tool, MSH assessed its compliance based on an average sample of 91% of Nutrition Type D.5.j.ii assessments due each month for the review period February-July 2010 (total of 193 out of 213):</p>																					

Section D: Integrated Assessments

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

Section D: Integrated Assessments

		<p>A review of the records of seven 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 enhance current practice.</p>
--	--	--

Section D: Integrated Assessments

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. Donna Gillard, RT, Assistant to Clinical Administrator</li> <li>2. Donnie Yoo, LCSW, Supervising Social Worker</li> <li>3. James Park, LCSW, Supervising Social Worker</li> <li>4. Maribel Forbes, LCSW, Supervising Social Worker</li> <li>5. Shirin Karimi, LCSW, Chief of Social Work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following nine individuals: AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL</li> <li>2. Integrated Assessments: Social Work Section</li> <li>3. 30-Day Psychosocial Assessments</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, March 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 Integrated Assessments: Social Work Sections due each month during the review period (February-July 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 80%;"><i>Is, to the extent reasonably possible, accurate,</i></td> <td style="width: 15%; text-align: center;">100%</td> </tr> <tr> <td style="text-align: center;">2.</td> <td><i>Current, and</i></td> <td style="text-align: center;">99%</td> </tr> <tr> <td style="text-align: center;">3.</td> <td><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td style="text-align: center;">100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate,</i>	100%	2.	<i>Current, and</i>	99%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
1.	<i>Is, to the extent reasonably possible, accurate,</i>	100%									
2.	<i>Current, and</i>	99%									
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%									

Section D: Integrated Assessments

		<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 nine individuals to evaluate the Integrated Assessments: Social Work Section found that all nine assessments were current and comprehensive (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL).</p> <p>A review of the records of nine individuals to evaluate the 30-Day Psychosocial Assessments found that all nine assessments were timely and comprehensive (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL).</p> <p><b>Other findings:</b> A review of MSH's SW staffing pattern found that the SW department had recruited three social workers during this review period. There is one more vacancy to be filled and one staff member is on medical leave, thereby leaving two open positions. There is one unit with only one SW staff and another, the female unit, is missing a SW staff.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH</p>

Section D: Integrated Assessments

		<p>assessed its compliance based on an average sample of 99% of the 30-Day Psychosocial Assessments due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 342 1892 493"> <tr> <td data-bbox="993 342 1087 415">4.</td> <td data-bbox="1087 342 1797 415"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1797 342 1892 415">100%</td> </tr> <tr> <td data-bbox="993 415 1087 456">5.</td> <td data-bbox="1087 415 1797 456"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1797 415 1892 456">100%</td> </tr> <tr> <td data-bbox="993 456 1087 493">6.</td> <td data-bbox="1087 456 1797 493"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1797 456 1892 493">100%</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 nine individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that eight assessments identified and resolved factual inconsistencies (AM, CJM, CKD, JH, LO, OEV, RRG and TL) and staff was waiting for additional information to resolve the inconsistency in the remaining record (BS).</p> <p><b>Compliance:</b> Substantial.</p> <p><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%
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%									
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><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation, March 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</p>									

Section D: Integrated Assessments

		<p>Integrated Assessments: Social Work Section due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 305 1892 342"> <tr> <td data-bbox="993 305 1087 342">7.</td> <td data-bbox="1087 305 1795 342"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1795 305 1892 342">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 the records of nine individuals to evaluate timeliness of the Integrated Assessment: Social Work Section found that all assessments were timely (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL).</p> <p>Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 786 1892 859"> <tr> <td data-bbox="993 786 1087 859">8.</td> <td data-bbox="1087 786 1795 859"><i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i></td> <td data-bbox="1795 786 1892 859">95%</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 nine individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that all nine assessments were timely (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	7.	<i>Is included in the 7-day integrated assessment</i>	99%	8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	95%
7.	<i>Is included in the 7-day integrated assessment</i>	99%						
8.	<i>Fully documented by the 30<sup>th</sup> day of the individual's admission.</i>	95%						

Section D: Integrated Assessments

<p>D.6.d</p>	<p>Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Audit and present data on social factors.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 100% of Integrated Assessments: Social Work Section due each month during the review period:</p> <table border="1" data-bbox="993 638 1892 675"> <tr> <td>10.</td> <td><i>Educational status</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>A review of the records of nine individuals to evaluate documentation of the individual's educational status in the Integrated Assessments: Social Work Section found that all nine assessments included information on the individual's educational status (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL).</p> <p>Using the DMH Social History Assessments Monitoring Form, MSH assessed its compliance based on an average sample of 99% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1195 1892 1232"> <tr> <td>10.</td> <td><i>Educational status</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>A review of the records of nine individuals to evaluate documentation of</p>	10.	<i>Educational status</i>	100%	10.	<i>Educational status</i>	100%
10.	<i>Educational status</i>	100%						
10.	<i>Educational status</i>	100%						

Section D: Integrated Assessments

		<p>the individual's educational status in the 30-day Psychosocial Assessments found that nine assessments included information on the individual's educational status (AM, BS, CJM, CKD, JH, LO, OEV, RRG and TL). A review of the same nine assessments for social factors also found that the assessments included adequate information on the individual's social factors.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
--	--	--

Section D: Integrated Assessments

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 will be 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	

Section D: Integrated Assessments

	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	

Section D: Integrated Assessments

	issues, to inform the courts and the facility where the individual will be housed after discharge.	
D.7.c	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.	
D.7.c.i	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.	

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p><b>Summary of Progress:</b> MSH has maintained substantial compliance with the requirements of Section E.</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. Donna Gillard, RT, Assistant to Clinical Administrator</li> <li>2. Donnie Yoo, LCSW, Supervising Social Worker</li> <li>3. James Park, LCSW, Supervising Social Worker</li> <li>4. Maribel Forbes, LCSW, Supervising Social Worker</li> <li>5. Shirin Karimi, LCSW, Chief of Social Work</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Charts of the following 20 individuals: ALS, BMW, BTB, CKD, CL, JEK, JH, JL, JRM, JSL, KEG, LJO, LO, OLM, OV, PC, PD, RAM, RS and SS</li> <li>2. Integrated Assessments: Social Work Section</li> <li>3. Social History Assessments</li> <li>4. List of individuals who met discharge criteria but remain hospitalized</li> <li>5. List of individuals assessed to need family therapy</li> <li>6. PSR Mall Hours of Service by Discipline</li> <li>7. CONREP communication to discharge referrals</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program II, unit 414) for monthly review of RS</li> <li>2. WRPC (Program V, unit 403) for quarterly review of OV</li> <li>3. WRPC (Program V, unit 405) for 14-day review of CL</li> <li>4. PSR Mall Group: Managing PTSD/Trauma Recovery</li> <li>5. PSR Mall Group: Substance Abuse Recovery</li> <li>6. PSR Mall Group: Coping Skills</li> <li>7. PSR Mall Group: Substance Abuse Recovery - Pros and Cons</li> </ol>

Section E: Discharge Planning and Community Integration

		8. Discharge and Resource Planning			
E.1	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed compliance based on an average sample of 21% of the quarterly and annual WRPCs held each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 638 1890 786"> <tr> <td data-bbox="991 638 1087 786">7.</td> <td data-bbox="1087 638 1793 786"><i>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.</i></td> <td data-bbox="1793 638 1890 786">97%</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 eight individuals found appropriate linkage between discharge criteria, foci of hospitalization and relevant PSR Mall groups/individual therapy in all eight WRPs (BMW, BTB, CKD, JH, JSL, KEG, LJO and LO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	7.	<i>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.</i>	97%
7.	<i>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.</i>	97%			
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths,	<b>Current findings on previous recommendation:</b>			

Section E: Discharge Planning and Community Integration

	<p>preferences, and personal life goals;</p>	<p><b>Recommendation, March 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 26% of quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 524 1892 638"> <tr> <td data-bbox="993 524 1087 638">1.</td> <td data-bbox="1087 524 1795 638"><i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i></td> <td data-bbox="1795 524 1892 638">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>A review of the records of seven individuals found that all seven 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 (BMW, BTB, JH, JSL, KEG, LJO and LO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%			
E.1.b	<p>the individual's level of psychosocial functioning;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>			

Section E: Discharge Planning and Community Integration

		<p><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 414 1892 453"> <tr> <td data-bbox="993 414 1087 453">2.</td> <td data-bbox="1087 414 1795 453"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1795 414 1892 453">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 eight individuals found that all eight WRPs included the individual's psychosocial functioning in the Present Status section (BMW, BTB, CKD, JH, JSL, KEG, LJO and LO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>The individual's level of psychosocial functioning</i>	100%
2.	<i>The individual's level of psychosocial functioning</i>	100%			
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, March 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 26% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p>			

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="993 228 1887 342"> <tr> <td data-bbox="993 228 1087 342">3.</td> <td data-bbox="1087 228 1793 342"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 228 1887 342">98%</td> </tr> </table> <p data-bbox="993 386 1887 451">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 495 1921 638">A review of the records of eight individuals found that six WRPs contained documentation that discharge barriers were discussed with the individual (BTB, CKD, JSL, KEG, LJO and LO), and two did not (BMW and JH).</p> <p data-bbox="993 682 1921 784">This monitor observed three WRP conferences (CL, OV and RS). Two of the WRPTs discussed discharged barriers with the individual (CL and OV), and the remaining team did not fully cover this process.</p> <p data-bbox="993 828 1140 893"><b>Compliance:</b> Substantial.</p> <p data-bbox="993 937 1457 1002"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	98%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	98%			
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p data-bbox="993 1052 1577 1084"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 1128 1457 1193"><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1237 1921 1414"><b>Findings:</b> Using the DMH Discharge Planning and Community Integration Auditing Form, MSH assessed its compliance based on an average sample of 26% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p>			

Section E: Discharge Planning and Community Integration

		<table border="1" data-bbox="991 228 1892 305"> <tr> <td data-bbox="991 228 1087 305">4.</td> <td data-bbox="1087 228 1793 305"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1793 228 1892 305">99%</td> </tr> </table> <p data-bbox="991 347 1877 415">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 457 1887 634">A review of the records of 11 individuals found that all 11 WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (BTB, CKD, JEK, JH, JRM, JSL, KEG, LJO, LO, PD and SS).</p> <p data-bbox="991 680 1140 745"><b>Compliance:</b> Substantial.</p> <p data-bbox="991 790 1457 855"><b>Current recommendation:</b> Continue to monitor this requirement.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	99%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	99%			
E.2	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 data-bbox="991 902 1577 935"><b>Current findings on previous recommendation:</b></p> <p data-bbox="991 976 1457 1040"><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="991 1086 1856 1263"><b>Findings:</b> Using the DMH WRP Observation Monitoring Form, MSH assessed its compliance based on an average sample of 22% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1305 1892 1416"> <tr> <td data-bbox="991 1305 1087 1416">12.</td> <td data-bbox="1087 1305 1793 1416"><i>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</i></td> <td data-bbox="1793 1305 1892 1416">100%</td> </tr> </table>	12.	<i>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</i>	100%
12.	<i>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</i>	100%			

Section E: Discharge Planning and Community Integration

		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <i>in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i> </td> <td style="width: 50%;"></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 eight individuals found that six WRPs contained documentation indicating that the individual was an active participant in the discharge process (BTB, JEK, JSL, KEG, PD and SS). The remaining two WRPs contained no documentation that the individual participated in the discussion (JRM and LJO).</p> <p>This monitor observed three WRPCs (CL, OV and RS). Two WRPTs engaged the individual in discharge matters (CL and OV) and one did not.</p> <p>A review of the records of eight individuals found that all eight WRPs contained measurable objectives and interventions to address the individual's discharge criteria, and prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services (BTB, JEK, JRM, JSL, KEG, LJO, PD and SS).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	<i>in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>	
<i>in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>				
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	Please see subcells for compliance findings.		

Section E: Discharge Planning and Community Integration

	<p>individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</p>							
<p>E.3.a</p>	<p>measurable interventions regarding these discharge considerations;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 26% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 711 1892 1047"> <tr> <td data-bbox="993 711 1087 971"></td> <td data-bbox="1087 711 1795 971"> <p><i>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:</i></p> </td> <td data-bbox="1795 711 1892 971"></td> </tr> <tr> <td data-bbox="993 971 1087 1047"> <p>6.</p> </td> <td data-bbox="1087 971 1795 1047"> <p><i>Measurable interventions regarding these discharge considerations</i></p> </td> <td data-bbox="1795 971 1892 1047"> <p>100%</p> </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 WRPs of eight individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all eight WRPs (BTB, JEK, JRM, JSL, KEG, LJO, PD and SS).</p> <p><b>Compliance:</b> Substantial.</p>		<p><i>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:</i></p>		<p>6.</p>	<p><i>Measurable interventions regarding these discharge considerations</i></p>	<p>100%</p>
	<p><i>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:</i></p>							
<p>6.</p>	<p><i>Measurable interventions regarding these discharge considerations</i></p>	<p>100%</p>						

Section E: Discharge Planning and Community Integration

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
E.3.b	the staff responsible for implement the interventions; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 26% of quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1"> <tr> <td>7.</td> <td><i>The interventions specify the name(s) of specific staff responsible for implementing each one</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>A review of the records of eight individuals found that all eight WRPs identified the staff member responsible for the interventions (BTB, JEK, JRM, JSL, KEG, LJO, PD and SS).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%			
E.3.c	The time frames for completion of the interventions.	<p><b>Current findings on previous recommendation:</b></p>			

Section E: Discharge Planning and Community Integration

		<p><b>Recommendation, March 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 26% of quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 524 1890 824"> <tr> <td data-bbox="991 524 1087 784"></td> <td data-bbox="1087 524 1795 784"><i>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:</i></td> <td data-bbox="1795 524 1890 784"></td> </tr> <tr> <td data-bbox="991 784 1087 824">8.</td> <td data-bbox="1087 784 1795 824"><i>The time frames for completion of interventions</i></td> <td data-bbox="1795 784 1890 824">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 the records of eight 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 (JEK, JRM, JSL, KEG, PD and SS). The remaining two WRPs did not specify a time frame or the stated time frame was not aligned with the next scheduled WRPC (BTB and LJO).</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>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:</i>		8.	<i>The time frames for completion of interventions</i>	99%
	<i>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:</i>							
8.	<i>The time frames for completion of interventions</i>	99%						

Section E: Discharge Planning and Community Integration

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:	<b>Compliance:</b> Substantial.															
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Ensure that the list of individuals referred for discharge is accurate and comprehensive.</p> <p><b>Findings:</b> MSH has a number of individuals who are being readied for placement referrals (AL, AS, BM, BS, GB-M, GP, JK, KG, LW, MT, PG, SB, TM and WL). In these cases, the SW staff is seeking clarification from CONREP or seeking information and clarification from the WRPTs. The "referred for discharge but still hospitalized" list has a total of 53 individuals. One individual has been on the list since 2007 (JL), one since 2008 (HC), thirteen since 2009, and the remaining 38 since 2010 (fourteen of the 38 were referred during this review period).</p> <p>The table below shows the individuals who have been on the list since 2009 and earlier, and their status as to why they are still hospitalized:</p> <table border="1" data-bbox="993 1036 1904 1406"> <thead> <tr> <th>Individual</th> <th>Referral</th> <th>Status as of July 2010</th> </tr> </thead> <tbody> <tr> <td>AD</td> <td>09/09</td> <td>Referred to La Casa, waiting for response.</td> </tr> <tr> <td>AS</td> <td>03/09</td> <td>Referred to Olive Vista, selectively mute, placement difficulty due to reluctance to communicate, long history of violence in previous placement.</td> </tr> <tr> <td>CMW</td> <td>08/09</td> <td>Referred for Community Care, denied by Landmark.</td> </tr> <tr> <td>DG</td> <td>10/09</td> <td>La Paz would be good for individual, but La Paz is not interested due to previous PA with La</td> </tr> </tbody> </table>	Individual	Referral	Status as of July 2010	AD	09/09	Referred to La Casa, waiting for response.	AS	03/09	Referred to Olive Vista, selectively mute, placement difficulty due to reluctance to communicate, long history of violence in previous placement.	CMW	08/09	Referred for Community Care, denied by Landmark.	DG	10/09	La Paz would be good for individual, but La Paz is not interested due to previous PA with La
Individual	Referral	Status as of July 2010															
AD	09/09	Referred to La Casa, waiting for response.															
AS	03/09	Referred to Olive Vista, selectively mute, placement difficulty due to reluctance to communicate, long history of violence in previous placement.															
CMW	08/09	Referred for Community Care, denied by Landmark.															
DG	10/09	La Paz would be good for individual, but La Paz is not interested due to previous PA with La															

Section E: Discharge Planning and Community Integration

			Paz staff. MSH would like to try La Paz and work for alternate placement if rejected.
EE	07/09		Waiting for IMD acceptance
HC	06/08		LACC asking CSW for work history for Medicare funding. The facility has no work history on record. Working with LACC to resolve issue.
JL	12/07		Individual prefers apartment but is not eligible. WRPT working to have individual consider a locked facility, and requesting individual to submit for medical evaluations especially related to kidney issues.
KF	10/09		Preparing packet for IMD placement.
KS	06/09		Accepted at Olive Vista, waiting for a bed opening.
MG	06/09		WRPT has requested a 30-day hold, individual has displayed physical assault to staff and peers.
MW	08/09		LACC processing IMD package. MSH is waiting for response.
RO	12/09		Moving up list at Landmark, no firm time for placement.
RS	09/09		WRPT requested a hold on placement packet. Individual has adjusted to new meds and achieved a period of stability. Referral packet is to be resubmitted.
SMC	02/09		Waiting for an IMD response.
TO	07/09		Court-ordered placement at Southpoint. Waiting for a bed.
<p>Documentation review (monthly discharge referral updates) found that SW staff has been taking the steps necessary to expedite placement of the individuals. In almost all cases, external factors (CONREP, court,</p>			

Section E: Discharge Planning and Community Integration

		<p>lack of beds, etc) keep the individual from being placed.</p> <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, March 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 26% of the quarterly and annual WRPs due each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 786 1890 1011"> <tr> <td data-bbox="991 786 1087 935"></td> <td data-bbox="1087 786 1795 935"><i>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:</i></td> <td data-bbox="1795 786 1890 935"></td> </tr> <tr> <td data-bbox="991 935 1087 1011">10.</td> <td data-bbox="1087 935 1795 1011"><i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i></td> <td data-bbox="1795 935 1890 1011">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 the records of eight individuals found that all eight WRPs contained documentation of the assistance needed by the individual in the new setting (ALS, BMW, BTB, JL, OLM, PC, RAM and SS).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>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:</i>		10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	99%
	<i>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:</i>							
10.	<i>Individuals receive adequate assistance in transitioning to the new setting. (E4b)</i>	99%						

Section E: Discharge Planning and Community Integration

E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of cell E.5 and sub-cells are not applicable to MSH as it does not serve children and adolescents.
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.	

<b>F. Specific Therapeutic and Rehabilitation Services</b>	
	<p><b>Summary of Progress on Psychiatric Services:</b> MSH has maintained substantial compliance with most of the requirements in this section.</p> <p><b>Summary of Progress on Psychological Services:</b></p> <ol style="list-style-type: none"><li>1. MSH has maintained substantial compliance with the requirements of Section F.2.</li><li>2. MSH has maintained the gains made in the By Choice incentive program.</li><li>3. MSH has maintained the gains made in the timeline for completion of the Neuropsychological evaluation.</li></ol> <p><b>Summary of Progress on Nursing Services:</b></p> <ol style="list-style-type: none"><li>1. MSH's significant efforts regarding the documentation of PRN and Stat medications have proven effective and the facility is in compliance with EP requirements in this area.</li><li>2. MSH has implemented additional strategies addressing changes in status to ensure that the nursing documentation is clinically adequate and appropriate. With focused and continued efforts, MSH should be able to achieve substantial compliance regarding this requirement.</li></ol> <p><b>Summary of Progress on Rehabilitation Therapy Services:</b> MSH has maintained substantial compliance with most requirements of Section F.4, with the exceptions of F.4.a.i and F.4.c.</p> <p><b>Summary of Progress on Nutrition Services:</b> MSH has maintained substantial compliance with all requirements of Section F.5 and should continue to enhance and improve current practice.</p> <p><b>Summary of Progress on Pharmacy Services:</b> MSH has maintained substantial compliance with the requirements of</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Section F.6 for eighteen months (four consecutive tours). As a result, the Court Monitor's evaluation of this section will 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 General Medical Services:</b> MSH has maintained substantial compliance with most EP requirements in this section. However, in the course of the facility's daily reviews of critical events, the facility leadership did not provide timely and appropriate guidance regarding needed immediate measures to ensure the safety of individuals at the facility.</p> <p><b>Summary of Progress on Infection Control:</b> MSH has achieved substantial compliance with the requirements of this section of the Enhancement Plan.</p> <p><b>Summary of Progress on Dental Services:</b> MSH's Dental Department has maintained substantial compliance in all but one area of the Enhancement Plan--refusals. The facility needs to focus its efforts on developing and implementing a facility-wide system for addressing and tracking refusals.</p>
--	--

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. Michael Barsom, MD, Medical Director</li> <li>2. Nady Hanna, MD, Assistant Medical Director</li> <li>3. Bala Gulasekaram, MD, Chief of Psychiatry</li> <li>4. Behnam Behnam, MD, Supervising Senior Psychiatrist, Chief of Professional Education</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 31 individuals: AB, AF, AM, ARG, DJ, DPP, FC, HO, JGH, JME, JNN, JS, LEY, LLF, LO, MA, MCT, MG, NHC, NSM, NV, RTL, SE, SM, SPR, TC, TG, WHB, WHC, WL, and YK</li> <li>2. DMH Admission Psychiatric Assessment Audit summary data (February - July 2010)</li> <li>3. DMH Integrated Psychiatry Assessment Audit summary data (February - July 2010)</li> <li>4. DMH Monthly PPN Audit summary data (February - July 2010)</li> <li>5. DMH PRN and Stat monitoring summary data (February - July 2010)</li> <li>6. DMH Movement Disorder Monitoring summary data (February - July 2010)</li> <li>7. ADR Tracking Log for the review period</li> <li>8. MSH aggregated data regarding ADRs (February - July 2010)</li> <li>9. Last ten ADRs for this reporting period</li> <li>10. Training guidelines for completion of electronic ADR form</li> <li>11. Intensive Case Analyses (ICAs) completed during this review period for three individuals: JM, MC (ICA for an MVR), and PL</li> <li>12. Seven Drug Utilization Evaluations (DUEs) completed during this review period: New Carbamazepine Protocol, Zolpidem, Second Generation Antipsychotics (serum amylase), Three Antipsychotics (intraclass polypharmacy) and Isoniazid</li> <li>13. Last ten MVRs for this reporting period</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>14. MSH aggregated data regarding medication variances (February - July 2010)</p> <p>15. Training guidelines for MVR Reporting</p> <p>16. Pharmacy and Therapeutics Committee Minutes during the review period</p>
<p>F.1.a</p>	<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 recommendation:</b></p> <p><b>Recommendation, March 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 62%, 76% and 23%, respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p><b>Other findings:</b> The following is an outline of the updates of DMH medication guidelines since the last review:</p> <ol style="list-style-type: none"> <li>1. New guidelines were added regarding the use of the status of asenapine (Saphris), iloperidone (Fanapt), lithium, antidepressant, carbamazepine and first generation antipsychotics;</li> <li>2. Appendices to the current guidelines were added to address Hyperprolactinemia, Tardive Dyskinesia, Neuroleptic Malignant Syndrome and Metabolic Syndrome;</li> <li>3. Changes/additions were made to existing protocols to address the following:             <ol style="list-style-type: none"> <li>a. Use of clozapine in terminally ill individuals in hospice care;</li> <li>b. Dosing and warning information regarding the use of depot olanzapine (Zyprexa Relprevv);</li> </ol> </li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>c. Risks of olanzapine use during pregnancy;  d. Risks of SSRI use during pregnancy;  e. Dosing of paliperidone palmitate (Invega Sustenna);  f. Loading dose strategy for haloperidol decanoate; and  g. Risks of SSRI use;</p> <p>4. Dose maximum table was added regarding desvenlafaxine (Pristiq), asenapine (Saphris), iloperidone (Fanapt), paliperidone palmitate (Invega Sustenna) and depot olanzapine (Zyprexa Relprevv); and</p> <p>5. Changes were made to the maximum doses of duloxetine (Cymbalta) and lithium.</p> <p>MSH has adopted all above-listed updates.</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="991 1008 1892 1195"> <thead> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>8.</td> <td><i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable, with specific behavioral indications; and special precautions to address risk factors, as indicated]</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 1344 1892 1421"> <thead> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td>7.</td> <td><i>Diagnostic formulation</i></td> <td>100%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable, with specific behavioral indications; and special precautions to address risk factors, as indicated]</i>	100%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation</i>	100%
Admission Psychiatric Assessment														
8.	<i>Plan of care [regular psychotropic medications, with rationale; PRN and/or Stat medication as applicable, with specific behavioral indications; and special precautions to address risk factors, as indicated]</i>	100%												
Integrated Psychiatric Assessment														
7.	<i>Diagnostic formulation</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>10.</td> <td><i>Psychopharmacology treatment plan</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 for both items.</p> <table border="1"> <tr> <td colspan="3"><b>Monthly PPN</b></td> </tr> <tr> <td>3.</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>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>	10.	<i>Psychopharmacology treatment plan</i>	100%	<b>Monthly PPN</b>			3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	92%
10.	<i>Psychopharmacology treatment plan</i>	100%									
<b>Monthly PPN</b>											
3.	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	92%									
F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1"> <tr> <td colspan="3"><b>Monthly PPN</b></td> </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>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>	<b>Monthly PPN</b>			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>	98%			
<b>Monthly PPN</b>											
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>	98%									
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.									
F.1.a.v	monitored appropriately for side effects;	<table border="1"> <tr> <td colspan="3"><b>Monthly PPN</b></td> </tr> <tr> <td>2.</td> <td><i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i></td> <td>99%</td> </tr> </table>	<b>Monthly PPN</b>			2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	99%			
<b>Monthly PPN</b>											
2.	<i>Significant developments in the individual's clinical status and of appropriate psychiatric follow up</i>	99%									

Section F: Specific Therapeutic and Rehabilitation Services

		<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></p> <p>92%</p>												
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p>												
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"> <thead> <tr> <th>Audit Tool</th> <th>Item numbers</th> <th></th> </tr> </thead> <tbody> <tr> <td>Admission Psychiatric Assessment</td> <td>8.a, 8.b and 8.c</td> <td>100%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>7 and 10</td> <td>100%</td> </tr> <tr> <td>Monthly PPN</td> <td>2, 3 and 5</td> <td>96%</td> </tr> </tbody> </table> <p>Comparative data indicated that MSH has maintained compliance of at least 90% from the previous review period for all averages.</p>	Audit Tool	Item numbers		Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%	Integrated Assessment (Psychiatry)	7 and 10	100%	Monthly PPN	2, 3 and 5	96%
Audit Tool	Item numbers													
Admission Psychiatric Assessment	8.a, 8.b and 8.c	100%												
Integrated Assessment (Psychiatry)	7 and 10	100%												
Monthly PPN	2, 3 and 5	96%												
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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the standardized DMH Monthly PPN tool to assess compliance, based on an average sample of 23% of individuals who have been</p>												

Section F: Specific Therapeutic and Rehabilitation Services

hospitalized for 90 or more days during the review period (February-July 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 26% and 33% 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>	97%
3.	<i>Documentation of the circumstances requiring PRN medication.</i>	99%
5.	<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>		
2.	<i>Safe administration of Stat medication.</i>	98%
4.	<i>Documentation of the circumstances requiring Stat medication.</i>	98%
6.	<i>Documentation of the individual's response to Stat medication.</i>	99%

Comparative data indicated that MSH has maintained a compliance rate

Section F: Specific Therapeutic and Rehabilitation Services

		<p>of at least 90% from the previous review period for all items.</p> <p><b>Other findings:</b> Same as in D.1.f.</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>Recommendation 1, March 2010:</b> Continue to monitor this requirement.</p> <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 (February-July 2010):</p> <table border="1" data-bbox="991 1044 1890 1307"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <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>98%</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>	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>	98%
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>	98%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Recommendation 2, March 2010:</b>  Continue to provide aggregated data (and data comparisons across review periods) regarding the total number of individuals receiving the following:</p> <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> <p><b>Findings:</b>  MSH provided the following data:</p> <table border="1" data-bbox="991 782 1890 1421"> <thead> <tr> <th></th> <th>Indicators</th> <th>Previous Period</th> <th>Current Period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Total number of individuals receiving benzodiazepines for 60 days or more</i></td> <td>44</td> <td>35</td> </tr> <tr> <td>2.</td> <td><i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance use disorder for 60 days or more</i></td> <td>27</td> <td>25</td> </tr> <tr> <td>4.</td> <td><i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i></td> <td>6</td> <td>7</td> </tr> <tr> <td>5.</td> <td><i>Total number receiving anticholinergics for 60 days or more</i></td> <td>68</td> <td>64</td> </tr> <tr> <td>6.</td> <td><i>Total number receiving anticholinergics and having a diagnosis of cognitive</i></td> <td>7</td> <td>8</td> </tr> </tbody> </table>		Indicators	Previous Period	Current Period	1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	44	35	2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance use disorder for 60 days or more</i>	27	25	4.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	6	7	5.	<i>Total number receiving anticholinergics for 60 days or more</i>	68	64	6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive</i>	7	8
	Indicators	Previous Period	Current Period																							
1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	44	35																							
2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance use disorder for 60 days or more</i>	27	25																							
4.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	6	7																							
5.	<i>Total number receiving anticholinergics for 60 days or more</i>	68	64																							
6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive</i>	7	8																							

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 190 1050 266"></td> <td data-bbox="1050 190 1610 266"><i>impairments (as above) or tardive dyskinesia or age 65 or above</i></td> <td data-bbox="1610 190 1753 266"></td> <td data-bbox="1753 190 1892 266"></td> </tr> <tr> <td data-bbox="989 266 1050 342">7.</td> <td data-bbox="1050 266 1610 342"><i>Total number with intra-class polypharmacy</i></td> <td data-bbox="1610 266 1753 342">174</td> <td data-bbox="1753 266 1892 342">183</td> </tr> <tr> <td data-bbox="989 342 1050 418">8.</td> <td data-bbox="1050 342 1610 418"><i>Total number with inter-class polypharmacy</i></td> <td data-bbox="1610 342 1753 418">82</td> <td data-bbox="1753 342 1892 418">49</td> </tr> </table>		<i>impairments (as above) or tardive dyskinesia or age 65 or above</i>			7.	<i>Total number with intra-class polypharmacy</i>	174	183	8.	<i>Total number with inter-class polypharmacy</i>	82	49	
	<i>impairments (as above) or tardive dyskinesia or age 65 or above</i>														
7.	<i>Total number with intra-class polypharmacy</i>	174	183												
8.	<i>Total number with inter-class polypharmacy</i>	82	49												
<p>The above data indicated that MSH has maintained caution with regard to the long-term use of benzodiazepines and anticholinergic medications, particularly for individuals at risk, and to the use of polypharmacy. The facility's data regarding item 4 were inconsistent with the data presented for the last review. This appeared to be due to the fact that the facility presented data regarding use of anticholinergics regardless of their duration although this monitor specifically requested data only for individuals receiving these medications for 60 days or more.</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> <ol style="list-style-type: none"> <li>1. Benzodiazepines in 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 individuals receiving the above types of medication regimens. The reviews found general evidence of substantial compliance. The following is an outline of the findings from chart reviews:</p>															

		<p><b><u>Benzodiazepine use</u></b></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>JME</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JNN</td> <td>Clonazepam</td> <td>Cannabis Abuse</td> </tr> <tr> <td>JS</td> <td>Clonazepam</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>LO</td> <td>Clonazepam and zolpidem</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>NV</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>SM</td> <td>Lorazepam</td> <td>Alcohol Dependence and Cannabis Abuse</td> </tr> <tr> <td>TG</td> <td>Lorazepam</td> <td>Alcohol Dependence</td> </tr> </tbody> </table> <p>This review found substantial compliance in the charts of JME, JNN, JS, LO and SM; partial compliance in the chart of TG; and noncompliance in the chart of NV (there was no justification in the documented rationale for the prescriptions for sertraline and clonazepam).</p> <p><b><u>Anticholinergic use</u></b></p> <p>At the time of this review, only two individuals were diagnosed with cognitive impairments and receiving long-term treatment with anticholinergic agents. Review of the charts of these two individuals (see table below) found compliance in both cases.</p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>LLF</td> <td>Diphenhydramine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>WL</td> <td>Hydroxyzine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p><b><u>Anticholinergic use for elderly individuals</u></b></p> <p>At the time of this review, no individual age 65 or above received treatment with anticholinergic agents.</p>	Individual	Medication(s)	Diagnosis	JME	Lorazepam	Polysubstance Dependence	JNN	Clonazepam	Cannabis Abuse	JS	Clonazepam	Borderline Intellectual Functioning	LO	Clonazepam and zolpidem	Polysubstance Dependence	NV	Clonazepam	Polysubstance Dependence	SM	Lorazepam	Alcohol Dependence and Cannabis Abuse	TG	Lorazepam	Alcohol Dependence	Individual	Medication(s)	Diagnosis	LLF	Diphenhydramine	Borderline Intellectual Functioning	WL	Hydroxyzine	Borderline Intellectual Functioning
Individual	Medication(s)	Diagnosis																																	
JME	Lorazepam	Polysubstance Dependence																																	
JNN	Clonazepam	Cannabis Abuse																																	
JS	Clonazepam	Borderline Intellectual Functioning																																	
LO	Clonazepam and zolpidem	Polysubstance Dependence																																	
NV	Clonazepam	Polysubstance Dependence																																	
SM	Lorazepam	Alcohol Dependence and Cannabis Abuse																																	
TG	Lorazepam	Alcohol Dependence																																	
Individual	Medication(s)	Diagnosis																																	
LLF	Diphenhydramine	Borderline Intellectual Functioning																																	
WL	Hydroxyzine	Borderline Intellectual Functioning																																	

		<p><b><u>Polypharmacy use</u></b></p> <table border="1"> <thead> <tr> <th data-bbox="991 264 1142 305">Individual</th> <th data-bbox="1142 264 1871 305">Medication(s)</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1142 342">AM</td> <td data-bbox="1142 305 1871 342">Ziprasidone, olanzapine, lithium and buspirone</td> </tr> <tr> <td data-bbox="991 342 1142 418">ARG</td> <td data-bbox="1142 342 1871 418">Risperidone, quetiapine, lithium, divalproex, citalopram and clonazepam</td> </tr> <tr> <td data-bbox="991 418 1142 456">FC</td> <td data-bbox="1142 418 1871 456">Olanzapine, risperidone, oxcarbazepine and benztropine</td> </tr> <tr> <td data-bbox="991 456 1142 493">HO</td> <td data-bbox="1142 456 1871 493">Clozapine, divalproex, fluvoxamine and quetiapine</td> </tr> <tr> <td data-bbox="991 493 1142 531">LEY</td> <td data-bbox="1142 493 1871 531">Carbamazepine, aripiprazole, sertraline and trazodone</td> </tr> <tr> <td data-bbox="991 531 1142 607">NSM</td> <td data-bbox="1142 531 1871 607">Clozapine, loxapine, clonazepam, amitriptyline and citalopram</td> </tr> <tr> <td data-bbox="991 607 1142 683">TC</td> <td data-bbox="1142 607 1871 683">Olanzapine, quetiapine, oxcarbazepine, divalproex, sertraline and buspirone</td> </tr> </tbody> </table> <p>The reviews found substantial compliance in the charts of AM, ARG, LEY, NSM and TC, and partial compliance in the charts of FC and HO.</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> </ol> </li> </ol>	Individual	Medication(s)	AM	Ziprasidone, olanzapine, lithium and buspirone	ARG	Risperidone, quetiapine, lithium, divalproex, citalopram and clonazepam	FC	Olanzapine, risperidone, oxcarbazepine and benztropine	HO	Clozapine, divalproex, fluvoxamine and quetiapine	LEY	Carbamazepine, aripiprazole, sertraline and trazodone	NSM	Clozapine, loxapine, clonazepam, amitriptyline and citalopram	TC	Olanzapine, quetiapine, oxcarbazepine, divalproex, sertraline and buspirone
Individual	Medication(s)																	
AM	Ziprasidone, olanzapine, lithium and buspirone																	
ARG	Risperidone, quetiapine, lithium, divalproex, citalopram and clonazepam																	
FC	Olanzapine, risperidone, oxcarbazepine and benztropine																	
HO	Clozapine, divalproex, fluvoxamine and quetiapine																	
LEY	Carbamazepine, aripiprazole, sertraline and trazodone																	
NSM	Clozapine, loxapine, clonazepam, amitriptyline and citalopram																	
TC	Olanzapine, quetiapine, oxcarbazepine, divalproex, sertraline and buspirone																	

Section F: Specific Therapeutic and Rehabilitation Services

		<p>g. Inter-class polypharmacy.</p> <p>3. Ensure that the response to Recommendation 2, sub-items a and d, addresses use for 60 or more days only.</p>						
F.1.d	<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 recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>Continue to monitor this requirement.</li> <li>Ensure documentation of adequate clinical monitoring of individuals at risk for endocrine dysfunction.</li> </ul> <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 (February-July 2010):</p> <table border="1" data-bbox="991 786 1892 1047"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <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>98%</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 10 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>	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>	98%
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>	98%						

Section F: Specific Therapeutic and Rehabilitation Services

Individual	Medication(s)	Diagnosis
AB	Quetiapine	Diabetes Mellitus, Obesity and Dyslipidemia,
AF	Clozapine	Diabetes Mellitus, Dyslipidemia, Overweight and Hypertension
DJ	Olanzapine and haloperidol	Diabetes Mellitus, Hyperlipidemia and Hypertension
DPP	Risperidone	Diabetes Mellitus, Dyslipidemia, Obesity and Hypertension
MA	Quetiapine	Metabolic Syndrome, Hyperlipidemia, Overweight and Diabetes Mellitus
MG	Risperidone	Diabetes Mellitus, Overweight, and Dyslipidemia
NHC	Olanzapine	Diabetes Mellitus and Obesity
RTL	Olanzapine	Diabetes Mellitus, Dyslipidemia, Obesity and Hypertension
SE	Clozapine	Diabetes Mellitus, Obesity and Dyslipidemia,
SPR	Olanzapine	Diabetes Mellitus, Obesity, hyperprolactinemia and Hypertension

The review found substantial compliance in eight charts (AB, AF, DJ, MA, NHC, RTL, SE and SPR) and partial compliance in two (DPP and MG).

In general, the chart reviews found improved clinical monitoring of individuals at risk for endocrine dysfunction. The psychiatric progress notes of DPP and MG included evidence of inadequate tracking of the status of individuals who suffered from dyslipidemia and received high-risk medication regimens. In general, the psychiatric progress notes did not address the status of vital signs in individuals receiving clozapine. However, there was evidence that the facility monitored the vital signs of these individuals at appropriate intervals.

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>																					
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 recommendation:</b></p> <p><b>Recommendation, March 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 100% samples of individuals relevant to each indicator during the review period (February-July 2010):</p> <table border="1" data-bbox="991 821 1894 1421"> <tr> <td data-bbox="991 821 1087 898">1.</td> <td data-bbox="1087 821 1795 898"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1795 821 1894 898">100%</td> </tr> <tr> <td data-bbox="991 898 1087 1008">2.</td> <td data-bbox="1087 898 1795 1008"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1795 898 1894 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1087 1122">3.</td> <td data-bbox="1087 1008 1795 1122"><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="1795 1008 1894 1122">100%</td> </tr> <tr> <td data-bbox="991 1122 1087 1198">4.</td> <td data-bbox="1087 1122 1795 1198"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1795 1122 1894 1198">100%</td> </tr> <tr> <td data-bbox="991 1198 1087 1312">5.</td> <td data-bbox="1087 1198 1795 1312"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1795 1198 1894 1312">100%</td> </tr> <tr> <td data-bbox="991 1312 1087 1388">6.</td> <td data-bbox="1087 1312 1795 1388"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1795 1312 1894 1388">100%</td> </tr> <tr> <td data-bbox="991 1388 1087 1421">7.</td> <td data-bbox="1087 1388 1795 1421"><i>The Movement Disorder is included in Focus 6 of the</i></td> <td data-bbox="1795 1388 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 evaluation was completed as for all individuals with complicated movement disorders.</i>	100%	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	100%	7.	<i>The Movement Disorder is included in Focus 6 of the</i>	100%
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 evaluation was completed as for all individuals with complicated movement disorders.</i>	100%																					
6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	100%																					
7.	<i>The Movement Disorder is included in Focus 6 of the</i>	100%																					

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 190 1094 228"></td> <td data-bbox="1094 190 1795 228"><i>WRP.</i></td> <td data-bbox="1795 190 1890 228"></td> </tr> <tr> <td data-bbox="989 228 1094 305">8.</td> <td data-bbox="1094 228 1795 305"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1795 228 1890 305">100%</td> </tr> </table>		<i>WRP.</i>		8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	100%
	<i>WRP.</i>							
8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	100%						
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for each item.</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 has remained unchanged from the previous review period to the current period.</li> <li>2. The total number of individuals with history of TD diagnosis has increased from two to five.</li> <li>3. The total number of individuals with positive AIMS test that did not reach the threshold of TD diagnosis has increased from 26 in the previous review period to 41 in the current period.</li> </ol> <p>The facility reported that practitioners were underreporting new cases of positive AIMS and individuals that have reached the threshold of TD, based on current AIMS score, that were previously on the positive AIMS list. As a corrective action, the facility reported the following:</p> <ol style="list-style-type: none"> <li>1. All individuals with positive AIMS test will be evaluated for TD by the Neurologist.</li> <li>2. Senior psychiatrists will continue to provide consultations for all individuals with positive AIMS regardless of the score.</li> <li>3. An electronic version of AIMS is being developed to improve tracking and ensure accuracy of the database.</li> </ol> <p><b>Other findings:</b>  This monitor reviewed the charts of six individuals who were diagnosed with tardive dyskinesia or R/O tardive dyskinesia. This review found that MSH has maintained its progress in this area as follows:</p>								

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> <li>1. The admission AIMS tests were completed in all the charts for individuals who were admitted during the past year.</li> <li>2. Quarterly AIMS testing was completed in most charts (JGH, WHB, WHC and YK).</li> <li>3. All WRPs included diagnosis, focus and corresponding objectives and interventions related to TD.</li> <li>4. In general, the psychiatric progress notes provided adequate tracking of the AIMS scores in the charts of all individuals reviewed.</li> <li>5. The objectives related to TD utilized appropriate learning outcomes in most charts (e.g. WHC).</li> <li>6. In general, the charts documented the use (or consideration of) antipsychotic medication regimens that were relatively safer than other alternatives for individuals with this condition.</li> <li>7. None of the charts reviewed included evidence of unjustified long-term use of anticholinergic medications.</li> <li>8. There was evidence of timely implementation of neurological evaluations to address questionable diagnosis of TD, when indicated (YK).</li> </ol> <p>The review found only a few deficiencies as follows:</p> <ol style="list-style-type: none"> <li>1. The psychiatric progress notes did not adequately track observational AIMS scores in individuals who refused formal testing (MCT).</li> <li>2. One WRP included an inappropriate objective related to TD (JGH).</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.f</p>	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Increase reporting of ADRs.</li> <li>• Ensure accuracy of data regarding total number of ADRs reported.</li> </ul> <p><b>Findings:</b> During this review period, MSH reported 110 ADRs (of which data analysis determined that nine were not actual ADRs) compared to 92 during the previous period.</p> <p><b>Recommendation 3, March 2010:</b> Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <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> <p><b>Findings:</b> The facility presented data regarding the total number of ADRs and a classification by probability and severity of the ADRs. During this review period, 110 ADRs were reported; further review by the facility determined that nine of these reports were not actual ADRs. However, the classification by probability data reported 129 ADRs, which did not sum to the total number of ADRs reported (110 or 101) and therefore are not presented in this report. The facility reported and analyzed two severe ADRs (quetiapine-induced dizziness and syncope and salicylate-</p>
--------------	--	---

Section F: Specific Therapeutic and Rehabilitation Services

and ibuprofen-induced vomiting and coffee ground emesis). The methodology, findings, recommendations and actions were adequate. Both events resulted in outside hospitalization of the individuals who were involved, but none of the ADRs resulted in permanent harm to an individual.

	Previous period	Current period
Total ADRs	92	110
<b>Classification of Probability of ADRs</b>		
Doubtful	5	N/A
Possible	62	N/A
Probable	21	N/A
Definite	4	N/A
<b>Classification of Severity of ADRS</b>		
Mild	47	N/A
Moderate	40	N/A
Severe	5	N/A

**Recommendation 4, March 2010:**

Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.

**Findings:**

The facility analyzed its ADR data and determined that the most common ADR reported was elevation of prolactin levels during treatment with antipsychotic agents. The Chief of Professional Education provided in-service training for MSH physicians regarding causes of prolactin elevation and proper ways of measuring prolactin level.

**Compliance:**

Partial (due to inaccurate data regarding probability scale).

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Increase reporting of ADRs.</li> <li>2. Ensure accuracy of data regarding the probability and severity scales.</li> <li>3. 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>4. Provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</li> </ol>
<p>F.1.g</p>	<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>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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, the facility conducted the following DUEs:</p> <ol style="list-style-type: none"> <li>1. Patterns of use of zolpidem;</li> <li>2. Monitoring of lipase and amylase;</li> <li>3. Implementation of new carbamazepine guidelines;</li> <li>4. Use and monitoring of isoniazid (INH); and</li> <li>5. Polypharmacy with three antipsychotic agents.</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The DUEs employed appropriate methodology and the conclusions, recommendations and actions were 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>
F.1.h	<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, March 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 reaction that was classified as category E or above; and</li> <li>g. Outline of ICAs, including description of variance, recommendations and actions taken.</li> </ol> <p><b>Findings:</b> MSH reported the following data regarding MVRs:</p>

Section F: Specific Therapeutic and Rehabilitation Services

Number of Medication Variances	Previous Period	Current Period
Prescribing	47	28
Transcribing	288	221
Ordering/Procurement	180	155
Dispensing	213	184
Administration	746	758
Drug Security	150	139
Documentation	655	431
<b>Total variances</b>	<b>2279</b>	<b>1916</b>

  

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
# 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

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="1003 191 1717 305"> <tr> <td>Outcome G</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table> <p data-bbox="989 350 1913 675">The facility conducted intensive case analysis (ICA) of two variances, only one of which was rated as category E or above. The first variance involved an individual who reportedly declined an asthma inhaler treatment for six months, but the MTR documented administration of the inhaler. The ICA for this variance employed adequate methodology and the findings, recommendations and actions were adequate. The second event involved an apparent administration variance due to misinterpretation by an employee of a physician's order for hydralazine. The documentation of the ICA for this event was inadequate.</p> <p data-bbox="989 721 1850 821"><b>Recommendation 2, March 2010:</b> Provide summary of analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p data-bbox="989 867 1902 1414"><b>Findings:</b> The facility conducted adequate review and analysis of its variance data during this review period. The total types of variances (1916 as reported in the progress report) reflected a notable decrease (16%) compared to total number of variances reported during the previous review period (2279). This decrease was attributed to a decline in the numbers of all variance types, particularly documentation variances (431 as compared to 655 during the previous period). An exception to this decline was a negligible increase in actual administration variances (758 as compared to 746 during the previous review period); a comparison between critical break points for current (137) and previous (142) review periods however reveals an actual if insignificant <i>decrease</i> in administrative variances. Potential variances (240) remained proportionally higher than actual variances (209), although increased administration variances contributed to an increase in overall actual variances.</p>	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0
Outcome G	0	0									
Outcome H	0	0									
Outcome I	0	0									

Section F: Specific Therapeutic and Rehabilitation Services

		<p>The trend of persistent elevations in transcribing, administration, and documentation variances has persisted through this review period with a noted decline in administration variances over the last quarter (May, June, and July of 2010). The facility reported adequate corrective actions to address the patterns/trends of variances in transcribing, administration and documentation variances.</p> <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 reaction that was classified as Category E or above; and</li><li>g. Outline of ICAs, including description of variance, recommendations and actions taken.</li></ol></li><li>2. Provide analysis of patterns and trends, with corrective/educational actions related to MVRs.</li><li>3. Improve documentation of all ICAs of variances.</li></ol>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.1.i</p>	<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 recommendation:</b></p> <p><b>Recommendation, March 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>Other findings:</b> During this review period, the facility gathered and presented outcome data that addressed a variety of measures of mental health services.</p> <p>The data 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. Unique count of individuals in restraint;</li> <li>9. Unique count of restraint events;</li> <li>10. Unique count of individuals in seclusion;</li> <li>11. Unique count of seclusion events;</li> <li>12. Individuals on benzodiazepines who are diagnosed with substance use;</li> <li>13. Individuals on benzodiazepine diagnosed with cognitive disorder;</li> <li>14. Elderly on anticholinergic medications (age &gt;65);</li> <li>15. Individuals diagnosed with cognitive disorder on anticholinergics;</li> <li>16. Individuals diagnosed with TD prescribed anticholinergics;</li> <li>17. Count of severe ADRs; and</li> </ol>
--------------	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>18. Count of severe medication variances.</p> <p>In addition, the facility presented data regarding the following indicators:</p> <ol style="list-style-type: none"> <li>1. Percentage of individuals receiving substance abuse services who advanced at least one stage of change (Stages 1 to 4) (increase); and</li> <li>2. Percentage of individuals receiving substance abuse services who maintained Stage 5 (increase).</li> </ol> <p>These outcome measures are addressed in various forms in relevant sections of this report as well as accompanying key indicators. However, 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 quantitative outcomes. Overall, the data appear to indicate positive outcomes. However, the facility has yet to ensure accuracy of these data because of some inconsistencies with similar data that were presented elsewhere in the report.</p> <p>At the request of this monitor, the facility assessed the areas of discrepancy and reported the following:</p> <p>During the collection of data for the above table, MSH noted that Key Indicator data from WaRMSS overestimated data in certain trigger categories. Initial analysis indicated that WaRMSS software definitions and algorithms did not match clinical definitions in certain categories such as polypharmacy. Specifically, for example, data in the above table from WaRMSS regarding polypharmacy did not match polypharmacy data in cell F1.c, which is collected from the Pharmacy Department database and verified through clinical review.</p> <p>MSH will initiate a statewide review of the WaRMSS Key Indicator data</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>with each facility Medical Director and Standards Compliance Department to identify areas of discrepancy and development of a standardized methodology for reporting.</p> <p><b>Compliance:</b> Partial.</p> <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. Provide outcome data as requested by this monitor and ensure consistency of data with similar data presented in other sections.</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, March 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 recommendation:</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, March 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>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Same as in F.1.a through F.1.h.</p> <p><b>Current recommendation:</b> Same as in F.1.a through F.1.h.</p>
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, March 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 recommendation:</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, March 2010:</b> Same as in F.1.c.</p> <p><b>Findings:</b> Same as in F.1.c.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Same as in F.1.c.</p>
F.1.m.ii	<p>all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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.iii	<p>all individuals prescribed benzodiazepines as a scheduled modality for more than two months;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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	<p>all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Same as above.</p> <p><b>Findings:</b> Same as above.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Same as above.</p>
F.1.m.v	<p>all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Same as F.1.e.</p> <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	<p>all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b> Same as in C.2.n, C.2.o and F.1.c.</p>
F.1.o	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice and present supporting documentation.</p> <p><b>Findings:</b> The facility's data showed substantial compliance with this requirement.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b> Continue current practice and present supporting documentation.</p>

Section F: Specific Therapeutic and Rehabilitation Services

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. Cynthia Lusch, Clinical Administrator</li> <li>2. Darren Sush, PsyD, PBS Team Leader, Coordinator Specialty Services</li> <li>3. Gretchen Hunt, By Choice Coordinator</li> <li>4. John Lusch, Mall Director</li> <li>5. Lamberto Domingo, PsyD, Psychologist</li> <li>6. Shawn Johnson, By Choice Assistant Coordinator</li> <li>7. Sheri Greve, PsyD, Acting Chief of Psychology</li> <li>8. Siobhan Donovan, PsyD, Senior Supervising Psychologist</li> <li>9. Victor Zermeno, Psychiatric Technician</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. The charts of the following 26 individuals: AM, AB, CL, DB, DE, DW, FDA, HQN, JH, JS, TC, MC, VA, VC, KO, WH, BY, KB, TG, LN, OV, RC, RS, SM, JR, and YVB</li> <li>2. Behavior Guidelines developed and implemented during this review period</li> <li>3. Focused Psychology Assessments completed during this review period</li> <li>4. List of Cognitive Rehabilitation groups</li> <li>5. List of individuals meeting trigger thresholds during this review period</li> <li>6. List of individuals referred for neuropsychology services</li> <li>7. Neuropsychology reports</li> <li>8. PBS Plan Fidelity Checks</li> <li>9. PBS Plan Outcome Data and Graphs</li> <li>10. PBS Staff Training Logs</li> <li>11. Positive Behavioral Support Plans (PBS)</li> <li>12. Protocol for cognitive disorders</li> <li>13. Psychology Specialist Services Committee Meeting Minutes (3/16/10 - 8/17/10)</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>14. Structural and Functional Assessment Reports  15. Completed Structural and Functional Assessment Instruments (QABF, FAI, QABF-MI, Reinforcement Inventory for Adults)  16. By Choice Incentive Store Utilization Data  17. Completed By Choice test following training  18. Completed Psychology Services Monitoring Forms  19. Positive Behavior Support Hospital Annual Update Presentation  20. Positive Behavior Support New Employee Orientation Presentation</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program II, unit 414) for monthly review of RS</li> <li>2. WRPC (Program V, unit 403) for quarterly review of OV</li> <li>3. WRPC (Program V, unit 405) for 14-day review of CL</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 professional standards of care, in the following areas:</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH has two PBS teams. The two PBS teams meet the 1:300 ratio required by the EP. A number of changes in the Psychology staffing level have taken place during this review period. MSH now has a new Acting Chief of Psychology and a new Psychology Specialty Services Coordinator, in addition to other changes at the Senior Psychologist level.</p> <p>Documentation review and interview of the PBS and Psychology Specialty Service Coordinator found that PBS team members continued to receive training on matters relating to PBS and behavioral interventions. The training topics covered during this review period include:</p> <ul style="list-style-type: none"> <li>• Functional analysis and challenging behavior;</li> <li>• Further evaluation of idiosyncratic functions for severe problem</li> </ul>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>behavior: aggression maintained by access to walks;</p> <ul style="list-style-type: none"> <li>• Differential reinforcement;</li> <li>• Functional behavior assessment; and</li> <li>• Active listening.</li> </ul> <p>PBS staff also received training from their consultant, Ms. Angela Adkins, on various topics including proper WRP documentation, structural and functional assessments, and writing comprehensive intervention plans.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.a.i	<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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Documentation review found that all new staff were trained on PBS at New Employee Orientation. The training was conducted using the New Employee PBS Training module (slide presentation, pop quizzes, and skills checks).</p> <p>A review of Structural and Functional Assessments and PBS plans and Behavioral Guidelines found that unit staff responsible for implementation of the behavioral intervention plans were trained and certified in the plans.</p> <p>See F.2.a for a description of PBS-related training provided during the review period.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			
F.2.a.ii	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Documentation review and interview of the By Choice coordinator found that the By Choice team had been conducting staff training and collecting fidelity data on a monthly basis.</p> <p>Using the DMH Psychology Monitoring-By Choice Form, MSH assessed its compliance based on an average sample of 21% of WRPs due each month of this review period (February-July 2010):</p> <table border="1" data-bbox="991 971 1892 1045"> <tr> <td data-bbox="991 971 1087 1045">2.</td> <td data-bbox="1087 971 1793 1045"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i></td> <td data-bbox="1793 971 1892 1045">91%</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 all eight of the WRPs s 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 (AB, AM, DE, FDA, HQN, JH, JS and YVB).</p> <p>This monitor observed three WRPCs (CL, OV and RS). Two of the WRPTs</p>	2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	91%
2.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</i>	91%			

Section F: Specific Therapeutic and Rehabilitation Services

(CL and OV) engaged the individuals in their By Choice point allocation process, used data to explain point achievements, and requested if the individual wanted to change the allocation of points, and one of the teams did not.

The following table summarizes staff training on By Choice during the review period (February-July 2010):

Staff Training in By Choice							
2010	Feb	Mar	Apr	May	Jun	Jul	Mean
Number of staff eligible for training	134	43	80	79	60	47	74
Number of staff trained	124	48	75	79	58	47	72
Percent of eligible staff trained	92%	100%	93%	100%	96%	100%	97%

According to the By Choice coordinator, the By Choice program trained a total of 436 staff in the six months during this review period.

Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, MSH assessed its compliance based on a sample of 22% of the a.m. and p.m. Level I nursing staff:

1.	<i>Staff understands the goal of the By Choice system</i>	100%
2.	<i>Staff can state the current point cycle</i>	99%
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>	99%

Section F: Specific Therapeutic and Rehabilitation Services

		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>	99%
		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>	98%
		10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	98%
		11.	<i>Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.</i>	N/A
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for all audited items. Item 11 pertains to the level system, which is not in place at this time. The facility indicated that it will monitor this item once it is in place.</p>				
<p><b>Other findings:</b> Using the Fidelity of Implementation by Individuals Form, MSH also assessed fidelity of By Choice implementation based on 20% sample of individuals in the facility:</p>				
		1.	<i>The individual understands the goal of the By Choice system.</i>	100%
		2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	92%
		3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	100%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 191 1066 305">4.</td> <td data-bbox="1066 191 1774 305"><i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i></td> <td data-bbox="1774 191 1871 305">100%</td> </tr> <tr> <td data-bbox="989 305 1066 378">5.</td> <td data-bbox="1066 305 1774 378"><i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i></td> <td data-bbox="1774 305 1871 378">100%</td> </tr> <tr> <td data-bbox="989 378 1066 456">6.</td> <td data-bbox="1066 378 1774 456"><i>Individual can indicate how many points he or she may earn each day.</i></td> <td data-bbox="1774 378 1871 456">99%</td> </tr> <tr> <td data-bbox="989 456 1066 529">7.</td> <td data-bbox="1066 456 1774 529"><i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i></td> <td data-bbox="1774 456 1871 529">93%</td> </tr> <tr> <td data-bbox="989 529 1066 607">8.</td> <td data-bbox="1066 529 1774 607"><i>Individual can correctly state the procedure for reallocating their By Choice points.</i></td> <td data-bbox="1774 529 1871 607">94%</td> </tr> <tr> <td data-bbox="989 607 1066 680">9.</td> <td data-bbox="1066 607 1774 680"><i>The individual is able to state their unit or program's incentive store hours of operation.</i></td> <td data-bbox="1774 607 1871 680">100%</td> </tr> <tr> <td data-bbox="989 680 1066 755">10.</td> <td data-bbox="1066 680 1774 755"><i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i></td> <td data-bbox="1774 680 1871 755">N/A</td> </tr> </table>	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>	100%	5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	100%	6.	<i>Individual can indicate how many points he or she may earn each day.</i>	99%	7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	93%	8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	94%	9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	100%	10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	N/A	
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>	100%																						
5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	100%																						
6.	<i>Individual can indicate how many points he or she may earn each day.</i>	99%																						
7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	93%																						
8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	94%																						
9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	100%																						
10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	N/A																						
		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1-6 and 9, and improved compliance for items 7 and 8 from 70% and 72% respectively. Item 10 pertains to the level system, which is not in place at this time. The facility indicated that it will monitor this item once it is in place.</p>																						
		<p>Using the By Choice Monitoring Form: Satisfaction Check, MSH surveyed a mean sample of 21% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>																						
		<table border="1"> <thead> <tr> <th data-bbox="989 1162 1066 1240"></th> <th data-bbox="1066 1162 1608 1240"></th> <th data-bbox="1608 1162 1740 1240">Previous period</th> <th data-bbox="1740 1162 1871 1240">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1240 1066 1318">1.</td> <td data-bbox="1066 1240 1608 1318"><i>By Choice motivates me to participate in treatment</i></td> <td data-bbox="1608 1240 1740 1318">72%</td> <td data-bbox="1740 1240 1871 1318">75%</td> </tr> <tr> <td data-bbox="989 1318 1066 1391">2.</td> <td data-bbox="1066 1318 1608 1391"><i>The point system motivates me to improve my behavior</i></td> <td data-bbox="1608 1318 1740 1391">73%</td> <td data-bbox="1740 1318 1871 1391">76%</td> </tr> <tr> <td data-bbox="989 1391 1066 1421">3.</td> <td data-bbox="1066 1391 1608 1421"><i>The point system motivates me to learn</i></td> <td data-bbox="1608 1391 1740 1421">69%</td> <td data-bbox="1740 1391 1871 1421">72%</td> </tr> </tbody> </table>			Previous period	Current period	1.	<i>By Choice motivates me to participate in treatment</i>	72%	75%	2.	<i>The point system motivates me to improve my behavior</i>	73%	76%	3.	<i>The point system motivates me to learn</i>	69%	72%						
		Previous period	Current period																					
1.	<i>By Choice motivates me to participate in treatment</i>	72%	75%																					
2.	<i>The point system motivates me to improve my behavior</i>	73%	76%																					
3.	<i>The point system motivates me to learn</i>	69%	72%																					

Section F: Specific Therapeutic and Rehabilitation Services

			<i>new skills</i>		
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	62%	67%
		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	68%	72%
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	78%	72%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	72%	74%
		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	68%	72%
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	71%	74%
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	69%	73%
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	79%	80%
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	70%	73%
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	67%	73%
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	63%	70%
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	79%	83%
		<p>According to the By Choice coordinator, the By Choice and Incentive Store staff are focusing on educating the individuals on store improvement through peer mentoring and staff interaction.</p> <p>Using the Fidelity of Implementation by the By Choice Staff Form, MSH further assessed fidelity of implementation based on a 100% sample of</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Incentive Store staff members and By Choice representatives:</p> <table border="1"> <tr> <td data-bbox="991 266 1087 378">1.</td> <td data-bbox="1087 266 1793 378"><i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i></td> <td data-bbox="1793 266 1887 378">93%</td> </tr> <tr> <td data-bbox="991 378 1087 490">2.</td> <td data-bbox="1087 378 1793 490"><i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i></td> <td data-bbox="1793 378 1887 490">98%</td> </tr> <tr> <td data-bbox="991 490 1087 570">3.</td> <td data-bbox="1087 490 1793 570"><i>The incentive store is well stocked with appropriate items from the incentive list.</i></td> <td data-bbox="1793 490 1887 570">36%</td> </tr> <tr> <td data-bbox="991 570 1087 646">4.</td> <td data-bbox="1087 570 1793 646"><i>The incentive store has an inventory control system to track inventory and individual preferences.</i></td> <td data-bbox="1793 570 1887 646">99%</td> </tr> <tr> <td data-bbox="991 646 1087 722">5.</td> <td data-bbox="1087 646 1793 722"><i>Individuals have substantive input into the items being offered in the Incentive Store.</i></td> <td data-bbox="1793 646 1887 722">99%</td> </tr> <tr> <td data-bbox="991 722 1087 799">6.</td> <td data-bbox="1087 722 1793 799"><i>The incentive store has a system to track and remove outdated food items.</i></td> <td data-bbox="1793 722 1887 799">100%</td> </tr> <tr> <td data-bbox="991 799 1087 875">7.</td> <td data-bbox="1087 799 1793 875"><i>There is a By Choice Manual located in the incentive store.</i></td> <td data-bbox="1793 799 1887 875">100%</td> </tr> <tr> <td data-bbox="991 875 1087 987">8.</td> <td data-bbox="1087 875 1793 987"><i>The Incentive Store staff has received appropriate training regarding incentive store policies and procedures.</i></td> <td data-bbox="1793 875 1887 987">100%</td> </tr> <tr> <td data-bbox="991 987 1087 1063">9.</td> <td data-bbox="1087 987 1793 1063"><i>The individuals bring their point cards to the store to make a purchase.</i></td> <td data-bbox="1793 987 1887 1063">97%</td> </tr> <tr> <td data-bbox="991 1063 1087 1140">10.</td> <td data-bbox="1087 1063 1793 1140"><i>There is a By Choice Calorie Activity Guide located in the incentive store.</i></td> <td data-bbox="1793 1063 1887 1140">97%</td> </tr> <tr> <td data-bbox="991 1140 1087 1216">11.</td> <td data-bbox="1087 1140 1793 1216"><i>There is an Alert List in the incentive store for staff reference.</i></td> <td data-bbox="1793 1140 1887 1216">100%</td> </tr> </table> <p data-bbox="991 1247 1894 1393">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for items 1, 2, 4-8, 10 and 11. The compliance rates for items 3 and 9 were 75% and 86% respectively in the previous period.</p>	1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	93%	2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	98%	3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	36%	4.	<i>The incentive store has an inventory control system to track inventory and individual preferences.</i>	99%	5.	<i>Individuals have substantive input into the items being offered in the Incentive Store.</i>	99%	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>	97%	10.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	97%	11.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%
1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	93%																																	
2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	98%																																	
3.	<i>The incentive store is well stocked with appropriate items from the incentive list.</i>	36%																																	
4.	<i>The incentive store has an inventory control system to track inventory and individual preferences.</i>	99%																																	
5.	<i>Individuals have substantive input into the items being offered in the Incentive Store.</i>	99%																																	
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>	97%																																	
10.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	97%																																	
11.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%																																	

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), MSH assessed fidelity of implementation based on average samples of 22% of the Level of Care Staff, 20% 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="991 412 1587 531"> <tr> <td>Level of Care Staff</td> <td>99%</td> </tr> <tr> <td>Individuals</td> <td>96%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>93%</td> </tr> </table> <p>The By Choice program representatives are currently Mall Assistants and are required to perform Mall duties as well as facilitate Mall groups.</p> <p>The By Choice coordinator is working to ensure that all individual are able to participate in the program and receive points for their participation. At present, a number of individuals are not able to receive their points, including those in Program 416 who have alternate groups, those who attend groups not assigned to them, and those who have clinic appointments.</p> <p>According to the By Choice coordinator, co-providers in Mall groups will document individuals who fail to bring point cards so points can be allotted to them later. According to the available data, about 67% of the individuals are served in the incentive stores, and the By Choice staff is planning to find out why the others are not using the By Choice stores. The By Choice coordinator is working with the DCAT leader to try and allocate By Choice points to address mild challenging behaviors prior to the need for behavioral intervention plans.</p> <p>This monitor visited a By Choice store. Information from staff and individuals indicated that the incentive stores are adversely affected due to budget shortage. Inventory runs out at the end of the month. Individuals are restricted to three items of any product. There are many</p>	Level of Care Staff	99%	Individuals	96%	By Choice Program Staff	93%
Level of Care Staff	99%							
Individuals	96%							
By Choice Program Staff	93%							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>individuals with thousands of By Choice points unable to spend on items of their choosing.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH now has a new Acting Chief of Psychology, Dr. Sheri Greve. According to Dr. Greve, there has been no change in the organization and management with the roles, duties, and responsibilities of the Chief of Psychology at it relates to the clinical and administrative responsibility for the Positive Behavior Supports team and the By Choice incentive program. The psychology staff and the By Choice coordinator interviewed indicated that the Acting Chief of Psychology works well with them, is available when the need arises, and is seen in the units supporting individuals and staff.</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>

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.2.c.i</p>	<p>behavioral assessments include structural and functional assessments and, as necessary, functional analysis;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 sample of 100% of individuals with a new or revised behavioral assessment during the review period (February-July 2010):</p> <table border="1" data-bbox="991 561 1890 1419"> <tr> <td data-bbox="991 561 1087 672">1.</td> <td data-bbox="1087 561 1793 672"><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="1793 561 1890 672">100%</td> </tr> <tr> <td data-bbox="991 672 1087 750">2.</td> <td data-bbox="1087 672 1793 750"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 672 1890 750">100%</td> </tr> <tr> <td data-bbox="991 750 1087 828">3.</td> <td data-bbox="1087 750 1793 828"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1793 750 1890 828">100%</td> </tr> <tr> <td data-bbox="991 828 1087 938">4.</td> <td data-bbox="1087 828 1793 938"><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="1793 828 1890 938">100%</td> </tr> <tr> <td data-bbox="991 938 1087 1049">5.</td> <td data-bbox="1087 938 1793 1049"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 938 1890 1049">100%</td> </tr> <tr> <td data-bbox="991 1049 1087 1127">6.</td> <td data-bbox="1087 1049 1793 1127"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 1049 1890 1127">100%</td> </tr> <tr> <td data-bbox="991 1127 1087 1205">7.</td> <td data-bbox="1087 1127 1793 1205"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1793 1127 1890 1205">100%</td> </tr> <tr> <td data-bbox="991 1205 1087 1315">8.</td> <td data-bbox="1087 1205 1793 1315"><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="1793 1205 1890 1315">100%</td> </tr> <tr> <td data-bbox="991 1315 1087 1354">9.</td> <td data-bbox="1087 1315 1793 1354"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 1315 1890 1354">100%</td> </tr> <tr> <td data-bbox="991 1354 1087 1419">10.</td> <td data-bbox="1087 1354 1793 1419"><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care</i></td> <td data-bbox="1793 1354 1890 1419">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 conducted with people (e.g., individual, level of care</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%																														
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 conducted with people (e.g., individual, level of care</i>	100%																														

Section F: Specific Therapeutic and Rehabilitation Services

		<p><i>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>MSH continues to ensure that structural and functional assessments are conducted prior to developing and implementing PBS plans. A review of 12 intervention plans (BY, DB, DW, JR, KO, LN, MC, MC, RC, SM, TG and VC) found that structural and functional assessments had been conducted prior to the development of the behavioral intervention plans. However, the quality of a number of assessments could use improvement in the following areas:</p> <ol style="list-style-type: none"> <li>1. Collect and analyze data for challenging behaviors on cycles, episodes, strength, etc. Do not be satisfied with the "frequency of occurrence" measure alone;</li> <li>2. Integrate mental illness and physical illness variables in the structural and functional assessment and data analysis;</li> <li>3. Resolve conflicts when different sources of data lead to different functions;</li> <li>4. Emphasize assessment of the behavior predictors (setting events, antecedents, establishing operations, and precursors);</li> <li>5. Where necessary, manipulate setting events, antecedents, and motivating variables to refine the hypothesis,</li> <li>6. Conduct second-level analysis to refine functions. Do not be totally dependent on the screening instruments; and</li> <li>7. Ensure that preventive strategies utilize the factors identified in the assessments.</li> </ol>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.ii	<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, March 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 sample of 100% of individuals with a new or revised behavioral assessment during the review period (February-July 2010):</p> <table border="1"> <tr> <td>12.</td> <td><i>Testable data-based hypotheses of the challenging behavior were developed</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.</p> <p>A review of eight PBS plans (KO, SM, SMcM, TC, TG, VA, VC and WH) found that the hypotheses in all eight were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	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%			
F.2.c.iii	<p>There is documentation of previous behavioral interventions and their effects;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a sample of 100% of individuals with a new or revised behavioral assessment during the review period (February-July 2010):</p> <table border="1" data-bbox="991 376 1892 492"> <tr> <td data-bbox="991 376 1087 492">5</td> <td data-bbox="1087 376 1795 492"><i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i></td> <td data-bbox="1795 376 1892 492">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 six PBS plans (BY, KO, MC-1, MC-2, TG and VC) found that all six had documented previous behavioral interventions and their effects.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%
5	<i>Pertinent records of the individuals challenging behavior were reviewed for antecedents, triggers events, and consequences.</i>	100%			
F.2.c.iv	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 new or revised PBS plans and behavior guidelines during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1230 1892 1346"> <tr> <td data-bbox="991 1230 1087 1346">17.</td> <td data-bbox="1087 1230 1795 1346"><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 1230 1892 1346">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs; and</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>least 90% from the previous review period.</p> <p>A review of 12 behavioral intervention plans (BY, DB, DW, JR, KO, LN, MC-1, MC-2, RC, SM, TG and VC) found that all 12 were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Suggestion for further improvement during the maintenance phase: a number of intervention plans fail to utilize fully the triggers, setting events, and antecedents identified in the assessments in the preventative strategies (e.g., BY, SM, VA and VC). It is important that the predictive and preventative elements be used at the various stages of the intervention phase (education, prevention, de-escalation, and reaction).</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 new or revised PBS plans and behavior guidelines during the review period (February-July 2010):</p> <table border="1" data-bbox="993 1192 1892 1305"> <tr> <td data-bbox="993 1192 1087 1305">22.</td> <td data-bbox="1087 1192 1797 1305"><i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i></td> <td data-bbox="1797 1192 1892 1305">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>	22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%
22.	<i>The PSSC ensures that the BG and PBS plan, as applicable, are monitored to ensure that the interventions are used consistently across all settings.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of eight individuals (BY, KB, KO, MC-1, TC, VA, VC and WH) found that MSH had conducted fidelity checks on all seven behavioral intervention plans. The data showed that the plans were implemented with high fidelity (&gt;90%). However, staff should pay careful attention to areas beyond implementation of the steps in the plan. For example, it has been noted that WH's PBS recommendation for use of a hand mitten when the individual had an injury to the hand was not followed through. Such and other milieu information and data need to be collected beyond just conducting checks for the steps of the plan.</p> <p>Suggestion for further improvement during the maintenance phase: MSH's treatment fidelity data documents the implementation of the steps identified in the intervention plans. However, it is important to ensure that more molecular aspects of the steps or components of the plans including idiosyncratic variables, non-verbal gestures, latency to reinforcement, response time to instructions, etc. are tracked and monitored. To make this meaningful, plan developers should identify such variables during the assessment phase to incorporate them in the plan, and when observing implementation of the plans.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.2.c.vi	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>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="991 305 1906 760"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>4</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>3</td> <td>1.2</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>Seclusion</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>%C</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1:1</td> <td>18</td> <td>19</td> <td>16</td> <td>14</td> <td>13</td> <td>15</td> <td>15.8</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>Aggression to others</td> <td>52</td> <td>54</td> <td>49</td> <td>40</td> <td>39</td> <td>21</td> <td>42.5</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>Aggression to self</td> <td>9</td> <td>27</td> <td>26</td> <td>31</td> <td>29</td> <td>25</td> <td>24.5</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> </tbody> </table> <p>The table above shows that the PSSC had reviewed all cases that had met threshold in the trigger key indicators. However, it appears that the team had "a priori" decided that many of these triggers were due to "non-social" and "mental illness" reasons. These assumptions are presumptive. Challenging behaviors can be multiply determined and possible reasons can only be ruled out through proper assessments. In addition, behavioral support by way of setting event and antecedent manipulations can be helpful to assist staff and the individuals, even for non-social and mental illness-related behaviors. In many cases, brief structural and functional assessment and data analysis are sufficient to get meaningful information for data-based decision making.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	DMH Psychology Services Monitoring Form									Feb	Mar	Apr	May	Jun	Jul	Mean	Restraint	4	0	0	0	1	3	1.2	%C	100	100	100	100	100	100	100	Seclusion	0	0	0	0	0	0	0	%C	-	-	-	-	-	-	-	1:1	18	19	16	14	13	15	15.8	%C	100	100	100	100	100	100	100	Aggression to others	52	54	49	40	39	21	42.5	%C	100	100	100	100	100	100	100	Aggression to self	9	27	26	31	29	25	24.5	%C	100	100	100	100	100	100	100
DMH Psychology Services Monitoring Form																																																																																																		
	Feb	Mar	Apr	May	Jun	Jul	Mean																																																																																											
Restraint	4	0	0	0	1	3	1.2																																																																																											
%C	100	100	100	100	100	100	100																																																																																											
Seclusion	0	0	0	0	0	0	0																																																																																											
%C	-	-	-	-	-	-	-																																																																																											
1:1	18	19	16	14	13	15	15.8																																																																																											
%C	100	100	100	100	100	100	100																																																																																											
Aggression to others	52	54	49	40	39	21	42.5																																																																																											
%C	100	100	100	100	100	100	100																																																																																											
Aggression to self	9	27	26	31	29	25	24.5																																																																																											
%C	100	100	100	100	100	100	100																																																																																											
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with	<b>Current findings on previous recommendation:</b>																																																																																																

Section F: Specific Therapeutic and Rehabilitation Services

	<p>other treatment modalities, including drug therapy;</p>	<p><b>Recommendation, March 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 new or revised PBS plans and behavior guidelines during the review period (February-July 2010):</p> <table border="1" data-bbox="993 488 1892 602"> <tr> <td data-bbox="993 488 1087 602">11.</td> <td data-bbox="1087 488 1793 602"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 488 1892 602">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 six PBS plans (BY, KO, MC-1, MC-2, TG and VC) found that all six contained documentation indicating that interdisciplinary discussions had been conducted (where appropriate) to better assess and address the individual's behaviors of concern.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%			
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, March 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 new or revised PBS plans and behavior guidelines during the review period (February-July 2010):</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="993 191 1900 305"> <tr> <td data-bbox="993 191 1094 305">19.</td> <td data-bbox="1094 191 1797 305"><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="1797 191 1900 305">100%</td> </tr> </table> <p data-bbox="993 347 1900 415">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 457 1900 636">A review of the records of six individuals with PBS plans or PBS assessments (BY, KO, MC-1, MC-2, TG and VC) found that all six of the WRPs in the charts had discussed the PBS plans in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections in the WRP.</p> <p data-bbox="993 683 1900 751"><b>Current recommendation:</b> Continue to monitor this requirement.</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>	100%
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>	100%			
F.2.c.ix	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 data-bbox="993 792 1900 824"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 867 1900 935"><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 977 1900 1123"><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of new or revised PBS plans and behavior guidelines during the review period (February-July 2010):</p> <table border="1" data-bbox="993 1156 1900 1237"> <tr> <td data-bbox="993 1156 1094 1237">24.</td> <td data-bbox="1094 1156 1797 1237"><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td data-bbox="1797 1156 1900 1237">100%</td> </tr> </table> <p data-bbox="993 1279 1900 1347">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 1390 1900 1416">This monitor's review of PBS plans, outcome data and WRPs found that</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%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the PBS teams have revised the plans when needed. For example, PBS plans of the following individuals had been revised more than once (BY, KO, MC and VC) and the data had been updated in the Present Status section of the WRPs.</p> <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, March 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 (February-July 2010):</p> <table border="1" data-bbox="993 857 1892 935"> <tr> <td data-bbox="993 857 1087 935">20.</td> <td data-bbox="1087 857 1797 935"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</i></td> <td data-bbox="1797 857 1892 935">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 (February-July 2010):</p> <table border="1" data-bbox="993 1230 1892 1308"> <tr> <td data-bbox="993 1230 1087 1308">21.</td> <td data-bbox="1087 1230 1797 1308"><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="1797 1230 1892 1308">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG.</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.</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%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of eight PBS plans and related assessment and staff training data (BY, KB, KO, MC, TC, VA, VC and WH) found that the staff responsible for implementing the PBS plans had been trained to competency in all eight cases.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.</p> <table border="1" data-bbox="1008 1006 1906 1269"> <tr> <td data-bbox="1008 1006 1108 1081">15.a.i</td> <td data-bbox="1108 1006 1766 1081"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1766 1006 1906 1081">100%</td> </tr> <tr> <td data-bbox="1008 1081 1108 1156">15.a.ii</td> <td data-bbox="1108 1081 1766 1156"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1766 1081 1906 1156">100%</td> </tr> <tr> <td data-bbox="1008 1156 1108 1269">15.b</td> <td data-bbox="1108 1156 1766 1269"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1766 1156 1906 1269">Not reported</td> </tr> </table> <p>The PBS team leader and PSSC coordinator stated that PBS team members had not indicated any conflict between their PBS-related work and their other duties.</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	Not reported
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%									
15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%									
15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	Not reported									

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Continue current practice.</p>
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, March 2010:</b> Continue to monitor this requirement.</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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH has a full DCAT. The team members continue to receive training jointly with the PBS teams; see F.2.a for a summary of joint training topics. Additionally, the DCAT team received training in Psychological Assessment: Cognitive and Intellectual Assessment Tools and Analysis,</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	serve also need positive behavioral supports.	
F.2.e	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The PSSC conducts joint meetings with the ETRC. The meetings are held on a weekly basis. Documentation review (meeting minutes and attendance logs) found that attendance at these meetings is high with most of the core members in regular attendance. The ETRC/PSSC meeting was cancelled for the week of this tour and this monitor was unable to observe one.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Psychology Services Monitoring Form, MSH assessed its compliance based on a 100% sample of referrals received each month during the review period (February-July 2010):</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <thead> <tr> <th></th> <th></th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuro-psychological assessments due for completion in the review month</i></td> <td>5</td> <td>7</td> <td>6</td> <td>6</td> <td>7</td> <td>7</td> <td>6</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>5</td> <td>7</td> <td>6</td> <td>6</td> <td>7</td> <td>7</td> <td>6</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>23 days</td> </tr> </tbody> </table> <p>As shown in the table above, there were 38 referrals for Neuropsychological Evaluations during this review period (compared to 39 during the previous review period), and the assessments and reports were completed on average within 23 days (substantially the same as in the previous review period), within the expected 30-day time frame for completion.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>			Feb	Mar	Apr	May	Jun	Jul	Mean	18.a. i	<i>Number of neuro-psychological assessments due for completion in the review month</i>	5	7	6	6	7	7	6	18.a. ii	<i>Of those in 18.a.i, number completed</i>	5	7	6	6	7	7	6	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							23 days
		Feb	Mar	Apr	May	Jun	Jul	Mean																														
18.a. i	<i>Number of neuro-psychological assessments due for completion in the review month</i>	5	7	6	6	7	7	6																														
18.a. ii	<i>Of those in 18.a.i, number completed</i>	5	7	6	6	7	7	6																														
18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							23 days																														
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	<b>Current findings on previous recommendation:</b>																																				

Section F: Specific Therapeutic and Rehabilitation Services

	<p>support plans, consultation for educational or other testing, and positive behavior support plan updates.</p>	<p><b>Recommendation, March 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>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

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. Cindy Lusch, RN, Clinical Administrator, Acting Nursing Administrator</li> <li>3. Linda Gross, RN, Nursing Coordinator, CNS</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH's progress report and data</li> <li>2. MSH's training rosters</li> <li>3. Medication Variance Reports for MAR and Narcotic blanks</li> <li>4. Medication Administration Monitoring audit for medication observation conducted on site</li> <li>5. Medical records for the following 44 individuals: BB, BJ, BKW, CAC, CMN, CPP, CW, DDK, DG, DJS, DLW, DRL, EDM, FR, GAA, JEM, JJB, JJL, JLC, JMM, JOE, JR, JS, KO, LAB, LDH, LG, LJ, LW, MHC, MKD, MLC, MWV, NV, OM, RLF, RNJ, RR, SAC, SH, SS, TC, VX and YAS</li> </ol> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. WRPC (Program III, unit 415) for monthly review of JA</li> <li>2. WRPC (Program V, unit 413) for 14-day review of KG-1</li> <li>3. WRPC (Program VI, unit 419) for monthly review of KG-2</li> <li>4. Shift report on unit 413</li> <li>5. Medication administration on unit 416</li> </ol>
<p>F.3.a</p>	<p>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</p>	<p><b>Compliance:</b> Substantial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	ensure:							
F.3.a.i	safe administration of PRN medications and Stat medications;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue strategies to ensure that specific behaviors are included in the physicians' orders for PRN and Stat medications.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 25% mean sample of PRNs administered each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 711 1892 748"> <tr> <td data-bbox="991 711 1087 748">1.</td> <td data-bbox="1087 711 1793 748"><i>Safe administration of PRN medications</i></td> <td data-bbox="1793 711 1892 748">97%</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>Using the DMH Nursing Services Monitoring Stat Audit, MSH assessed its compliance based on a 33% mean sample of Stat medications administered each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1045 1892 1083"> <tr> <td data-bbox="991 1045 1087 1083">2.</td> <td data-bbox="1087 1045 1793 1083"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 1045 1892 1083">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 141 PRN and Stat orders (81 PRN and 60 Stat) for 35 individuals (BB, BJ, BKW, CMN, CPP, DDK, DJS, DLW, DRL, EDM, FR, GAA, JEM, JJB, JJB, JLC, JMM, JOE, JR, KO, LAB, LDH, LG, LJ, LW, MHC, MKD, MLC, MWV, OM, RNJ, SH, SS, VX and YAS) found all included specific individual behaviors. In addition, all notes reviewed</p>	1.	<i>Safe administration of PRN medications</i>	97%	2.	<i>Safe administration of Stat medications</i>	98%
1.	<i>Safe administration of PRN medications</i>	97%						
2.	<i>Safe administration of Stat medications</i>	98%						



Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="993 228 1892 380"> <tr> <td data-bbox="993 228 1087 380">4.</td> <td data-bbox="1087 228 1795 380"><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="1795 228 1892 380">98%</td> </tr> </table> <p data-bbox="993 418 1892 488">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 532 1892 672">A review of 60 incidents of Stat medications for 11 individuals (BB, BKW, CMN, CPP, JMM, JR, LG, LW, MKD, OM and RNJ) found adequate documentation in the IDNs of the circumstances requiring the PRN in all incidents.</p> <p data-bbox="993 716 1892 786"><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>	98%
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>	98%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p data-bbox="993 829 1892 862"><b>Current findings on previous recommendation:</b></p> <p data-bbox="993 906 1892 971"><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p data-bbox="993 1015 1892 1154"><b>Findings:</b> Using the DMH Nursing Services Monitoring PRN Audit, MSH assessed its compliance based on a 25% mean sample of PRNs administered each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 1192 1892 1308"> <tr> <td data-bbox="993 1192 1087 1308">5.</td> <td data-bbox="1087 1192 1795 1308"><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 1192 1892 1308">99%</td> </tr> </table> <p data-bbox="993 1349 1892 1414">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</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%
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%			



Section F: Specific Therapeutic and Rehabilitation Services

		<p>Narcotic log blanks to CNS and the NEC each week. CNS/Nursing Performance Improvement analyze all the MVRs to identify trends. This data is presented to the NCs to ensure follow-up is completed at the unit level. A review of a random sample of 50 MVRs found that MSH had MVRs for the missing initials and signatures on the MARs and Narcotic logs that were reported from the nightly audits.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> No nursing care plans or nursing diagnoses other than in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.d	<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, March 2010:</b> Continue to monitor this requirement.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<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="993 415 1892 565"> <tr> <td data-bbox="993 415 1087 565">8.</td> <td data-bbox="1087 415 1797 565"><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="1797 415 1892 565">95%</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 three WRPCs observed by this monitor, most team members were very familiar with the individual's WRP goals and interventions. 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> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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>	95%
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>	95%			
F.3.e	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	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Implement strategies to improve documentation related to change of status (in terms of the quality of the nursing assessments and of documentation in the Present Status section of the WRP).</li> <li>• Continue to monitor this requirement.</li> </ul>			

Section F: Specific Therapeutic and Rehabilitation Services

	<p>State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</p>	<p><b>Findings:</b> Using the DMH Medical Transfer Audit, MSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 376 1890 602"> <tr> <td data-bbox="991 376 1087 488">1.</td> <td data-bbox="1087 376 1793 488"><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 376 1890 488">96%</td> </tr> <tr> <td data-bbox="991 488 1087 602">7.</td> <td data-bbox="1087 488 1793 602"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 488 1890 602">96%</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 10 individuals who were transferred to a community hospital/emergency room (CW, DG, JMM, JS, LW, NV, RLF, RR, SAC and TC) found that that there were significant problematic issues with the nursing documentation for all of the reviewed individuals. Examples of problematic issues included:</p> <ul data-bbox="991 979 1906 1414" style="list-style-type: none"> <li>• Inadequate and incomplete assessments and follow-up for symptoms of low blood pressures and drops in oxygen saturations;</li> <li>• Inadequate assessments for complaints of pain;</li> <li>• No assessment of bowel data for an individual with decreased bowel sounds;</li> <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 assessments of an individual who reported hearing voices to hurt self and/or others regarding mood or changes in mood, affect,</li> </ul>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%	7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	96%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	96%						
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	96%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>ability to contract with staff regarding safety, presence of thoughts of self-harm, presence of a plan for self harm; documentation indicated that the individual was told to drink water and return to the reflection room;</p> <ul style="list-style-type: none"> <li>• Lack of documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room;</li> <li>• The lack of supervision by 1:1 staff for individual at risk for self-harm;</li> <li>• Difficulty in determining from progress notes and change of status forms the times at which individuals are sent to the community hospital/ER;</li> <li>• No summary documented of treatments provided at the community hospital or ER;</li> <li>• No documentation that a physician was timely notified when an individual was having multiple seizures;</li> <li>• Lack of a complete nursing assessment addressing the symptoms that precipitated the hospitalization or ER visit upon return to the facility;</li> <li>• Lack of neurological checks and documentation of mental status for individuals with a significant change in mental/health status;</li> <li>• Inadequate documentation of seizure activity, how long activity lasted, and assessment of individuals experiencing seizures;</li> <li>• Some Change of Status Forms report information regarding the individual's status from previous days that was not found in the progress notes;</li> <li>• Illegible progress notes, signatures and titles;</li> <li>• Lack of regular assessment of bowel sounds, abdomen, and regularity of bowel movements for individuals with constipation;</li> <li>• Lack of documentation that status changes had been timely reported to physician; including name of physician;</li> <li>• Duplication of documentation in progress notes and the Change of Status form;</li> <li>• Discrepancies in documentation between information contained in the</li> </ul>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>progress notes and Change of Status forms;</p> <ul style="list-style-type: none"> <li>• The inconsistent use of the Change of Status forms when documenting changes in status ; and</li> <li>• A number of progress notes out of sequential order.</li> </ul> <p>These findings do not comport with MSH's data. From discussions with Nursing, in May 2010 the CNS department began receiving notification when individuals are sent to the community hospital or ER and upon their return in order to review the nursing documentation to identify areas in need of improvement. Nursing reported that although the items reflected in the monitoring tool showed high compliance, the facility was aware that the quality of the RN documentation needed improvement. The facility implemented training sessions for the unit RNs and the Program HSS group regarding reviews of actual change of status cases transferred to community hospitals and ERs to identify areas of the nursing documentation in need of improvement. Thus far, 38 RNs have received this training. MSH reported that having an HSS assigned to each program to provide mentoring was beneficial and beginning in August 2010, an HSS will be assigned to individual units.</p> <p>Although the Facility reported that nursing had implemented mentoring for issues related to change of status, the overall deficits found indicate that significant work in this area needs to continue to attain substantial compliance with this requirement. The auditor(s) for this area should consider reading the "story" first regarding the change of status, keeping in mind that it may have begun days prior to the hospitalization or ER visit, to assess for the strengths and deficits in the nursing documentation. Reading only selective notes does not provide an accurate assessment of compliance for changes in status. In addition, clinical competency is required to be able to audit this area. Collaboration with the facility's Nurse Practitioners would be a valuable teaching and mentoring tool to build and improve nursing competency in this area.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Using the DMH Nursing Services Audit, MSH assessed its compliance based on a 10% sample of Change of Shift Reports observed during in the review months (February-July 2010):</p> <table border="1" data-bbox="991 375 1892 488"> <tr> <td data-bbox="991 375 1087 488">10.</td> <td data-bbox="1087 375 1795 488"><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 375 1892 488">95%</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 413 found that the report did not include or provide clinically relevant information to the oncoming shift. In fact, in some cases the information provided was not accurate regarding Mall group attendance and individualized symptoms. In addition, the information on the projected Kardex needed updating related to the Axis I diagnoses. A review of 12 Nursing Shift Report audits noted problems such as the need to report assessments for medical conditions, no information regarding seizures reported, missing staff members, issues related to the individuals' symptoms not linked with diagnoses, and outcomes of appointments. However, these audits were inappropriately scored to reflect compliance in this area.</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. 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</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>	95%
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>	95%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the nursing documentation and then score the monitoring tool.</p> <ol style="list-style-type: none"> <li>3. Collaborate with the Facility's Nurse Practitioners to teach and mentor to build and improve nursing competency regarding changes in status.</li> <li>4. Ensure that audits addressing change of shift report accurately reflect the shift report observed.</li> <li>5. Continue to monitor this requirement.</li> </ol>			
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> Partial.</p>			
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 25% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 1008 1892 1084"> <tr> <td>11.</td> <td><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td>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>From observations of medication administration on Unit 416, the medication nurse demonstrated some good interaction with most of the individuals. However, one individual was very agitated prior to coming for medications and continued to be agitated while standing at the medication room door. When the individual became angry and walked away from the</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	98%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	98%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>medication nurse, a number of staff including the medication nurse and the nurse conducting the observation with the reviewer began inappropriately laughing loudly. Consequently, the individual became even more agitated and began yelling. The facility nurse observing this medication administration did not provide appropriate feedback and correction addressing this inappropriate interaction. Medication education was appropriately provided.</p> <p>In addition, the medication nurse was not aware of a procedure for an individual (SC) that included having the individual stay with the medication nurse for 15 minutes after receiving medications to ensure the individual was not cheeking medications, as had been recently suspected.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Ensure that staff who administer medications are trained to deal appropriately with agitated individuals.</li> <li>2. Ensure that staff are aware of individual procedures for medication administration.</li> <li>3. Continue to monitor this requirement.</li> </ol>			
F.3.f.ii	education is provided to individuals during medication administration;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 25% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 1339 1890 1414"> <tr> <td data-bbox="991 1339 1087 1414">12.</td> <td data-bbox="1087 1339 1795 1414"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1795 1339 1890 1414">98%</td> </tr> </table>	12.	<i>Education is provided to individuals during medication administration.</i>	98%
12.	<i>Education is provided to individuals during medication administration.</i>	98%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for reviewer's findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 25% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 898 1887 971"> <tr> <td data-bbox="993 898 1087 971">13.</td> <td data-bbox="1087 898 1795 971"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1795 898 1887 971">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>See F.3.f.i for reviewer's findings.</p> <p><b>Current recommendations:</b> See F.3.f.i.</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	99%			
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	<p><b>Current findings on previous recommendation:</b></p>			

		<p><b>Recommendation, March 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 25% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 488 1892 599"> <tr> <td data-bbox="991 488 1087 599">14.</td> <td data-bbox="1087 488 1793 599"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 488 1892 599">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>MSH was able to produce MVRs for the blanks found on the MTRs and Narcotic Logs during the review period. The facility continues to put a significant amount of effort into analyzing the current medication administration system to evaluate strategies to implement so that medication nurses have the time they need to appropriately administer medications and interact with the individuals during medication administration.</p> <p>While observing medication administration, this reviewer noted that the time a PRN was given was not included on the Medication Administration Records. From discussions with Nursing, the facility had stopped documenting the time a PRN or Stat medication was given on the MARs and was only documenting this information on the back of the MAR and in the progress notes. Nursing needs to document the medication, dosage, route and time administered for PRNs and Stat medications on the Medication Administration Record according to generally accepted standards of practice.</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	98%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	98%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Provide retraining to staff addressing the need to document the medication, dosage, route and time administered for PRNs and Stat medications on the Medication Administration Record.</li> <li>2. Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice.</li> <li>3. Continue to monitor this requirement.</li> </ol>			
F.3.g	<p>Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Using the DMH Nursing Services Monitoring Form for Nursing Bed-Bound Audit, MSH assessed its compliance based on a 100% sample of individuals who were bed bound during in the review months (February-July 2010):</p> <table border="1" data-bbox="993 898 1892 971"> <tr> <td data-bbox="993 898 1087 971">15.</td> <td data-bbox="1087 898 1793 971"><i>There is a physician order justifying the clinical reason for the "bed bound" status.</i></td> <td data-bbox="1793 898 1892 971">100%</td> </tr> </table> <p>There were no bed-bound individuals during the previous review period and thus no comparative data.</p> <p>A review the record of one bed-bound individual (CAC) found that the documentation contained clinical justification of the "bed bound" status.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	15.	<i>There is a physician order justifying the clinical reason for the "bed bound" status.</i>	100%
15.	<i>There is a physician order justifying the clinical reason for the "bed bound" status.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

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:	<b>Compliance:</b> Substantial.
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's training rosters verified that the 20 newly hired nursing staff received and passed competency training addressing the requirements of F.3.h.i-iii.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.3.h.i.</p> <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, March 2010:</b> Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b> See F.3.h.i.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.3.i	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH's training rosters verified that the 275 licensed nursing staff due for annual training completed and passed the competency-based training for this requirement. Also see F.3.h.i for training data</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

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, Acting Rehabilitation Therapy Chief</li> <li>2. Beth Chapman, Physical Therapist</li> <li>3. Jamie Critie, Supervising Rehabilitation Therapist</li> <li>4. Kim Corrick, Occupational Therapist</li> <li>5. Lisa Adams, Supervising Rehabilitation Therapist</li> <li>6. Rebecca McClary, Acting Supervising Rehabilitation Therapist</li> <li>7. Ricardo Jurado, Speech Therapist</li> <li>8. Ruth Flores, Supervisor of Vocational Services</li> <li>9. Terez Henson, Supervising Rehabilitation Therapist</li> <li>10. Troy Zelones, Physical Therapist</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. F.4 audit data for February-July 2010</li> <li>2. MSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review</li> <li>3. Records of the following 16 individuals participating in observed PSR Mall groups: AS, BJB, DDK, DL, DM, FG, HF, JA, JAC, JAM, MD, MIJ, MMS, RM, TC and WP</li> <li>4. List of individuals who received direct physical therapy services from February-July 2010</li> <li>5. List of individuals who received direct speech therapy services from February-July 2010</li> <li>6. List of individuals who received direct occupational therapy services from February-July 2010</li> <li>7. Records of the following 10 individuals who received direct physical, occupational, and speech therapy and occupational therapy services from February-July 2010: CAC, CC, CW, DGB, FR, JR, JS, SE, TCG and ZB</li> <li>8. List of individuals with a 24-Hour Rehabilitation Support Plan</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>9. Records of the following two individuals with 24-Hour Rehabilitation Support Plans: ALM and DC</p> <p>10. Records for the following five individuals with INPOP plans: EEA, HC, KWM, LB and LG</p> <p>11. Records for the following four individuals with decubitus and/or at high risk for impaired skin integrity: JJW, KG, RCF and VF</p> <p>12. 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: JR and TP</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> <li>1. Court Readiness PSR Mall group</li> <li>2. DBT through Music PSR Mall group</li> <li>3. Gardening PSR Mall group</li> <li>4. Leisure Education PSR Mall group</li> <li>5. Recreation Therapy PSR Mall group</li> <li>6. Social Skills PSR Mall group</li> <li>7. Social Skills through Music 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 sub-cells for compliance findings.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b>          During the maintenance period, develop and implement a process to follow up with individuals who have been discharged from direct treatment secondary to refusals, address reasons for refusal during WRPC, implement strategies to encourage attendance and participation in direct treatment, and re-refer for services when clinically appropriate.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b>  The POST Refusals log maintained by the POST Supervising Rehabilitation Therapist (SRT) was reviewed and found to track individual name, date of refusal, treatment type refused, reason for refusal, and indication as to whether the individual was discharged due to three consecutive refusals. However, it was noted that no individuals on the log were listed as having been discharged, which is inconsistent with findings of record reviews.</p> <p>The facility reported that the process for addressing the issue of individuals who have been discharged due to refusals includes monthly follow-up by the POST SRT in the form of notices to WRPT RTs.</p> <p><b>Recommendation 2, March 2010:</b>  Continue to improve and enhance current practice.</p> <p><b>Findings:</b>  The table below presents the number of scheduled vs. actual hours/ sessions of direct services provided by OT, PT, and SLP during the week of 6/21/2010 - 6/25/2010:</p> <table border="1" data-bbox="991 1003 1591 1159"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>PT</td> <td>32</td> <td>23</td> </tr> <tr> <td>OT</td> <td>17</td> <td>12</td> </tr> <tr> <td>SLP</td> <td>6</td> <td>6</td> </tr> </tbody> </table> <p>The facility reviewed the reasons for the discrepancy between sessions scheduled and sessions provided and reported that OT and PT sessions were missed due to individual refusing, medical issues, and time conflicts.</p> <p>Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 60% of individuals receiving occupational, speech</p>		Scheduled	Provided	PT	32	23	OT	17	12	SLP	6	6
	Scheduled	Provided												
PT	32	23												
OT	17	12												
SLP	6	6												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>and/or physical therapy direct treatment during the review period February-July 2010:</p> <table border="1" data-bbox="993 302 1890 378"> <tr> <td data-bbox="993 302 1087 378">1.</td> <td data-bbox="1087 302 1795 378"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1795 302 1890 378">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 10 individuals receiving direct occupational, physical, and/or speech therapy treatment to assess compliance with F.4.a.i criteria found seven records in substantial compliance (CAC, CC, CW, DGB, SE, TCG and ZB) and three records in partial compliance (FR, JR and JS).</p> <p><b>Other findings:</b>          Upon review of POST documentation for 10 individuals seen in direct treatment and for 12 individuals who received POST focused assessments, inconsistencies were noted in terms of forms used and quality of documentation of progress in therapy as well as written objectives and interventions. Therapists should be encouraged to use DMH-approved forms for documentation and assessments, with training as needed by a mentor who is familiar with the WRP process and requirements.</p> <p>In regard to quality and inclusion of objectives, only five out of 12 records of individuals who received OT, PT, SLP, or CIPRTA assessments showed evidence of objectives that were written according to facility required standards and were included in the WRP document.</p> <p>In terms of individualized outcomes, record review found that six out of 10 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes, three individuals were discharged (two</p>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	93%
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	93%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>due to refusals and one due to discharge to acute care facility) and for one individual, progress was unable to be determined based on the quality of documentation reviewed.</p> <p>Six records were reviewed for individuals who had met triggers for falls, had decubitus, or met criteria for being at high risk for impaired skin integrity. Of these six records, it appeared that POST referrals were clinically indicated to address risk issues for four individuals, and one out of four records indicated that individuals were referred for and received appropriate assessment and/or therapy interventions.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendation:</b> 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>			
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to enhance and improve current practice.</p> <p><b>Findings:</b> Using the DMH F.4 Monitoring Tool, MSH assessed its compliance based on an average sample of 23% of plans completed during the review period February-July 2010:</p> <table border="1" data-bbox="991 1300 1887 1412"> <tr> <td data-bbox="991 1300 1087 1412">2.</td> <td data-bbox="1087 1300 1780 1412"><i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i></td> <td data-bbox="1780 1300 1887 1412">100%</td> </tr> </table>	2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	100%
2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of five records of individuals with INPOP programs found that all five were in substantial compliance with F.4.a.ii.criteria. A review of an individual who was receiving PT direct treatment (DGB) and was discharged due to refusals found that an INPOP program might have been appropriate for this individual, though no mention of this option was found in POST documentation.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</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>
F.4.b	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to enhance and improve current practice.</p> <p><b>Findings:</b> The facility reported that 23/23 nurses identified as requiring training in areas including the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period.</p> <p><b>Compliance:</b> Substantial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Current recommendation:</b> Continue to improve and enhance current practice.</p>			
F.4.c	<p>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> During the maintenance period, develop and implement a process to ensure that all individuals who meet criteria for the development and implementation of a 24-hour support plan receive this service.</p> <p><b>Findings:</b> This recommendation has not been met. While individuals on the SNF unit were observed during mealtime, this was the only functional area targeted, and only for individuals on units 418 and 419. There has not been a systemic effort to ensure that all individuals in the hospital who meet criteria for development and implementation of a 24-hour support plan to promote safety and independence are identified and provided with this service.</p> <p><b>Recommendation 2, March 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 26% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period February-July 2010:</p> <table border="1" data-bbox="991 1263 1890 1377"> <tr> <td data-bbox="991 1263 1087 1377">4.</td> <td data-bbox="1087 1263 1795 1377"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1795 1263 1890 1377">95%</td> </tr> </table>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	95%
4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	95%			

Section F: Specific Therapeutic and Rehabilitation Services

		<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 16 individuals participating in Rehabilitation Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found 11 records in substantial compliance (BJB, DL, FG, HF, JAC, JAM, MIJ, MMS, RM, TC and WP) and five records in partial compliance (AS, DDK, DM, JA and MD).</p> <p>In terms of individualized outcomes, record review found that six out of 16 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes, nine out of 16 individuals did not make progress, and for one individual, progress was unable to be determined due to recent commencement of participation in the Mall group.</p> <p>Observation of five PSR Mall groups found that the appropriate lesson plan was in use and the group facilitators provided activities that were in line with the individuals' assessed needs in all groups. It was noted that some lesson plans were general, with no variation in written lessons from week to week.</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 February-July 2010:</p> <table border="1" data-bbox="993 1190 1890 1304"> <tr> <td data-bbox="993 1190 1087 1304">4.</td> <td data-bbox="1087 1190 1780 1304"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1780 1190 1890 1304">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%
4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of records of two individuals with 24-hour support plans to assess compliance with F.4.c criteria found one record in substantial compliance (DC) and one record in partial compliance (ALM).</p> <p>The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Vocational Rehabilitation during the week of 04/19/10 - 04/23/10.</p> <table border="1" data-bbox="993 524 1661 643"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>445</td> <td>370</td> </tr> <tr> <td>Voc Rehab</td> <td>20</td> <td>18</td> </tr> </tbody> </table> <p>The facility reported that the discrepancy between hours scheduled and hours provided was due to staff furloughs.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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.</li> <li>2. 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.</li> </ol>		Scheduled	Provided	RT	445	370	Voc Rehab	20	18
	Scheduled	Provided									
RT	445	370									
Voc Rehab	20	18									
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive	<b>Current findings on previous recommendation:</b>									

Section F: Specific Therapeutic and Rehabilitation Services

	<p>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>Recommendation, March 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 each month and 85% of individuals requiring reassessment during the review period February-July 2010:</p> <table border="1" data-bbox="993 524 1892 902"> <tr> <td data-bbox="993 524 1087 597">e.</td> <td data-bbox="1087 524 1780 597"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1780 524 1892 597">100%</td> </tr> <tr> <td data-bbox="993 597 1087 670">f.</td> <td data-bbox="1087 597 1780 670"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1780 597 1892 670">100%</td> </tr> <tr> <td data-bbox="993 670 1087 743">g.</td> <td data-bbox="1087 670 1780 743"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1780 670 1892 743">100%</td> </tr> <tr> <td data-bbox="993 743 1087 816">h.</td> <td data-bbox="1087 743 1780 816"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1780 743 1892 816">100%</td> </tr> <tr> <td data-bbox="993 816 1087 902">i.</td> <td data-bbox="1087 816 1780 902"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1780 816 1892 902">100%</td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate greater than 90% from the previous review period for all items.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</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%															

Section F: Specific Therapeutic and Rehabilitation Services

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. Chris Marshall, Director of Nutrition Services</li> <li>2. Denise Manos, Assistant Director of Nutrition Services</li> <li>3. Mary Ramirez, Assistant Director of Nutrition Services</li> <li>4. Portia Salvacion, Assistant Director of Nutrition Services</li> <li>5. Virginia A. Tovar, Assistant Director of Nutrition Services</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Lists of individuals with Nutrition Care Assessments due from February-July 2010 for each assessment type</li> <li>2. Records of the following 36 individuals with types a-j.ii assessments from February-July 2010: AN, ASG, BAM, CC, CLH, CP, EN, FR, GAA, GL, HF, HI, HL, JB, JK, JM, KD, MB, MG, MSN, MW, MWK, NR, OD, RA, RB, RS-1, RS-2, RSP, SLF, SNG, ST, TG, TLD, TP and WDT</li> <li>3. Meal Accuracy Report audit data from February-July 2010</li> <li>4. Nutrition Care Monitoring Tool audit data from February-July 2010 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 two individuals at risk for choking and aspiration: DC and EL</li> <li>7. List of individuals with a new diabetes diagnosis during the review period</li> <li>8. List of individuals at risk for metabolic syndrome</li> <li>9. Records for the following four individuals with a new diabetes diagnosis of diabetes during the review period: DM, MKN, MN and VMC</li> <li>10. Records for the following three individuals at high risk for metabolic syndrome: GABM, GYG and REG</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>11. List of individuals receiving enteral nutrition                  12. Records for the following five individuals receiving enteral nutrition:                  ALM, CW, HC, HLM and JA</p> <p><u>Observed:</u>                  Nutrition PSR Mall Group</p>						
<p>F.5.a</p>	<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, March 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 66% of Nutrition Assessments (all types) due each month from February-July 2010 (total of 935 out of 1413):</p> <table border="1" data-bbox="993 857 1892 1010"> <tr> <td data-bbox="993 857 1087 898">7.</td> <td data-bbox="1087 857 1797 898"><i>Nutrition education is documented.</i></td> <td data-bbox="1797 857 1892 898">100%</td> </tr> <tr> <td data-bbox="993 898 1087 1010">8</td> <td data-bbox="1087 898 1797 1010"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1797 898 1892 1010">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 37 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>According to review of Meal Accuracy Report data, 100% of trays (regular and modified diets) audited from February-July 2010 (total of</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%						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>776 out of 3877, for a 20% sample) were 100% accurate. Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p><b>Other findings:</b>  A review of records for four individuals with a new diagnosis of diabetes found that three of four individuals had evidence of a subsequent nutrition assessment, update, and/or nutrition objectives and interventions in the WRP to address risk. One record (DM) had evidence of objective and intervention to address diabetes, but no referral was found for nutrition assessment due to change in status and new diagnosis. A review of records for three individuals at high risk for metabolic syndrome found that nutrition assessments addressed contributing risk factors in all three records and nutrition recommendations were incorporated in the WRP. One nutrition objective for individual GYG was not incorporated into the WRP, though this may have been due to a WRP decision.</p> <p><b>Compliance:</b>  Substantial.</p> <p><b>Current recommendation:</b>  Continue to enhance current practice.</p>
F.5.b	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 66% of Nutrition Assessments (all types) due each month from February-July</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>2010 (total of 935 out of 1413):</p> <table border="1" data-bbox="993 264 1892 453"> <tr> <td data-bbox="993 264 1087 339">19.</td> <td data-bbox="1087 264 1780 339"><i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i></td> <td data-bbox="1780 264 1892 339">100%</td> </tr> <tr> <td data-bbox="993 339 1087 453">20.</td> <td data-bbox="1087 339 1780 453"><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="1780 339 1892 453">97%</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 33 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 enhance current practice.</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>	97%
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>	97%						
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, March 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> 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>The facility reported no incidences of aspiration pneumonia for the</p>						

Section F: Specific Therapeutic and Rehabilitation Services

		<p>review period, and the facility does not track choking incidents, so this number could not be determined. Record review for two individuals at high risk for choking and/or aspiration found that both had documentation of an open focus, objective and intervention to remediate risk and/or future occurrence. However, review of both records appeared to indicate that these individuals might benefit from a 24-hour support plan to address risk. While one record (DC) stated that the individual had a 24-hour support plan, no evidence of this plan was found in the record. See Section F.4 for additional findings on implementation of 24-hour support plans.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to 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, March 2010:</b> Continue to enhance current practice.</p> <p><b>Findings:</b> The facility reported that two new dietitians were hired during the review period and were trained to competency on the training materials related to dysphagia and aspiration.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to enhance current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.5.e</p>	<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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b>                  During the maintenance period, ensure that optimal and appropriate clinical pathways are followed in order to ensure potential return to oral intake whenever possible.</p> <p><b>Findings:</b>                  The facility reported that the speech therapist is currently completing quarterly reviews for all individuals who are receiving enteral nutrition, and for all individuals who are NPO, the SLP is performing re-assessments to determine whether return to oral intake is possible. Record review verified that this process has been implemented in that all five records reviewed showed evidence of quarterly reassessment, though in two records (ALM and CW), documentation was not detailed enough to offer a sufficient explanation of the clinical rationale for continued NPO status, or provide a description as to how the reassessment was completed (e.g., PO trials, interview). One individual (CW) was NPO due to refusals, but it was reported that she was willing and able to eat food provided by her family during family visits. However, no evidence of psychological or behavioral consultation or interventions was found in the WRP.</p> <p><b>Recommendation 2, March 2010:</b>                  Continue to improve and enhance current practice.</p> <p><b>Findings:</b>                  A review of the records of five individuals receiving enteral nutrition found evidence in all five WRPs that enteral supports were individualized, and in three out of five records, evidence was found that PO trials were attempted. Three out of five records had documentation of reassessment information regarding clinical justification and rationale of NPO status in the WRP. One individual who was previously NPO was</p>
--------------	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>returned to PO status following speech therapy assessment and intervention and is now eating by mouth, which is aligned with his life goal to eat.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to improve and enhance current practice.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

6. Pharmacy Services																											
	<p>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:</p>	<p><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>Glen Itow, PharmD, Director, Pharmacy Department</li> <li>Harold Plon, PharmD, Assistant Director, Pharmacy Department</li> <li>Michael Barsom, MD, Medical Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>MSH data regarding recommendations made by the pharmacists and physicians' response to these recommendations (February - July 2010)</li> <li>MSH pharmacy recommendation that was not followed, without rationale documented, for the review period.</li> </ol>																									
F.6.a	<p>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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement and provide comparative data regarding number and type of recommendations during the review period compared to the last period.</p> <p><b>Findings:</b> MSH presented the following data regarding the recommendations made during the current review period:</p> <table border="1" data-bbox="991 1154 1873 1421"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>29</td> <td>21</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>58</td> <td>88</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>58</td> <td>55</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>11</td> <td>13</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>6</td> <td>9</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	29	21	2.	Side effects	58	88	3.	Need for laboratory testing	58	55	4.	Dose adjustment	11	13	5.	Indications	6	9
		Previous period	Current period																								
1.	Drug-drug interactions	29	21																								
2.	Side effects	58	88																								
3.	Need for laboratory testing	58	55																								
4.	Dose adjustment	11	13																								
5.	Indications	6	9																								

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="993 191 1871 345"> <tr> <td>6.</td> <td>Contraindications</td> <td>1</td> <td>0</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>1</td> <td>4</td> </tr> <tr> <td>8.</td> <td>Others</td> <td>23</td> <td>41</td> </tr> <tr> <td colspan="2">Total number of recommendations*</td> <td>187</td> <td>231</td> </tr> </table> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and self-monitoring.</p>	6.	Contraindications	1	0	7.	Need for continued treatment	1	4	8.	Others	23	41	Total number of recommendations*		187	231
6.	Contraindications	1	0															
7.	Need for continued treatment	1	4															
8.	Others	23	41															
Total number of recommendations*		187	231															
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.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement and provide comparative data for the review period compared to the last period.</p> <p><b>Findings:</b></p> <table border="1" data-bbox="993 901 1795 1166"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>164</td> <td>202</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>21</td> <td>28</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>2</td> <td>1</td> </tr> </tbody> </table> <p>This monitor reviewed the only recommendation that was not followed and no rationale was documented. The review found no evidence of harm to the individual. However, there should be documentation of the rationale for not following the pharmacy recommendations in all situations.</p>		Previous period	Current period	Recommendations followed	164	202	Recommendations not followed, but rationale documented	21	28	Recommendations not followed and rationale/response not documented	2	1				
	Previous period	Current period																
Recommendations followed	164	202																
Recommendations not followed, but rationale documented	21	28																
Recommendations not followed and rationale/response not documented	2	1																

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and self-monitoring.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

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. Alan Ta, MD, Physician and Surgeon</li> <li>3. Azar Izadian, MD, Neurology Consultant</li> <li>4. Chi Vu, MD, Physician and Surgeon</li> <li>5. Hani Benyamin, MD, Physician and Surgeon</li> <li>6. Joseph James, MD, Staff Psychiatrist</li> <li>7. Michael Barsom, MD, Medical Director</li> <li>8. Niza Uy-Uyan, MD, Physician and Surgeon</li> <li>9. Parvaneh Zolnouni, MD, Physician and Surgeon</li> <li>10. Raymond Flores, MD, Physician and Surgeon</li> <li>11. Teneese Nguyen, MD, Physician and Surgeon</li> <li>12. Thai Vu, MD, Physician and Surgeon</li> <li>13. Trang Tran, MD, Physician and Surgeon</li> <li>14. 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 10 individuals who were transferred to outside hospitals for acute care during this review period: CW, DG, JM, JS, LW, NV, RF, RR, SC and TC</li> <li>2. Mortality Review reports/investigations of unexpected deaths for the following six individuals: CR, DG, DR, IS, JT and NA</li> <li>3. Copy of Monthly Key Indicator Report with correction of unexpected death in January 2010</li> <li>4. Quarterly Medical Assessment Notes on the following 10 individuals: AD, BJB, GMM, GS, JEK, JR, LG, LT, MO and SE</li> <li>5. List of all individuals admitted to external hospitals during the review period.</li> <li>6. MSH Laboratory Test Interpretation policy, July 29, 2010</li> <li>7. MSH Seizure Disorder Review Form</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<ol style="list-style-type: none"> <li>8. MSH Uncontrolled Diabetes Mellitus Audit form</li> <li>9. MSH Report to CM on 9/2/10; new systems (implemented), new projects (ongoing)</li> <li>10. MSH Physician Coverage Schedule (February - August 2010)</li> <li>11. DMH Medical Surgical Progress Note auditing summary data (February - July 2010)</li> <li>12. DMH Medical Transfer auditing summary data (February - July 2010)</li> <li>13. DMH Medical Emergency Response auditing summary data (February - July 2010)</li> <li>14. DMH Medical Emergency Response Drill auditing summary data (February - July 2010)</li> <li>15. DMH Integration of Medical Conditions into the WRP auditing summary data (February - July 2010)</li> <li>16. MSH Required Documentation from Outside Consultations/Hospitals summary data (February - July 2010)</li> <li>17. DMH Diabetes Mellitus auditing summary data (February - July 2010)</li> <li>18. DMH COPD/Asthma auditing summary data (February - July 2010)</li> <li>19. DMH Hypertension auditing summary data (February - July 2010)</li> <li>20. DMH Dyslipidemia auditing summary data (February - July 2010)</li> <li>21. MSH Preventative Care auditing summary data (February - July 2010)</li> <li>22. MSH Cardiac Disease auditing summary data (July 2010)</li> <li>23. MSH Metabolic Syndrome auditing summary data (February - July 2010)</li> <li>24. MSH Medicine Peer Review data (March 2010 and June 2010)</li> <li>25. 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> <li>• Bowel Dysfunction</li> <li>• Falls</li> <li>• Aspiration Pneumonia (clinical outcome only)</li> </ul> </li> </ol>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> <li>• Seizure Disorder (clinical outcome only)</li> <li>• Specialty Consultations (process outcome only)</li> <li>• Unexpected Mortalities</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>Recommendation 1, March 2010:</b> Implement corrective actions to address the monitor's findings of deficiencies [in this cell in the previous report].</p> <p><b>Findings:</b> The facility implemented adequate corrective actions to address the findings of deficiencies. The following is a summary of these actions:</p> <ol style="list-style-type: none"> <li>1. The requirement to address the circumstances of any fall, Nursing Policy 102.1, was reinforced by the nursing supervisor and is being monitored. Physicians were instructed by the Chief Physician and Surgeon to perform a complete post-fall assessment including detailed neurological examination. Medications prescribed to individuals at risk of fall were closely monitored by the senior psychiatrists and at the Medical Risk Management Committee reviews to ensure that medications which can increase individuals' risks for fall are either substituted with different medications or the dosages are reduced.</li> <li>2. During departmental monthly meetings, primary care physicians were instructed by the Chief Physician and Surgeon to adhere to the requirements of SO 136, the MSH policy regarding the provision of medical care to individuals, when ordering laboratory tests.</li> <li>3. A new procedure was developed and approved by the Clinical Laboratory Consultant and the Chief Physician and Surgeon to be implemented in August 2010. This procedure addressed the possibility of discrepant results from different laboratories. In addition, practice guidelines on the management of abnormal</li> </ol>

Section F: Specific Therapeutic and Rehabilitation Services

		<p>lipase/amylase values were distributed to all primary care physicians and psychiatrists. The guidelines addressed the approach to elevated lipase/amylase values in asymptomatic individuals.</p> <p>In addition, the facility implemented the following corrective actions:</p> <ol style="list-style-type: none"> <li>1. In July 2010, MSH hired a new full-time neurologist with subspecialty in behavioral neurology. This is expected to enhance the care provided to individuals with seizure disorders, dementias, movement disorders and other neurological conditions.</li> <li>2. The Chief Physician and Surgeon developed a tracking system to follow diabetic patients with elevated HgbA1c to ensure that proper actions are taken to achieve adequate control of the diabetic condition and to avoid the occurrence of complications.</li> <li>3. The Chief Physician and Surgeon developed a new Seizure Disorder Review Form to establish a more complete database on all MSH individuals with seizures. The form will be completed by the neurologist and information will be related to both the psychiatrist and the PCP of the individual. This process was implemented in August 2010.</li> <li>4. The facility implemented an enhanced system for Medical Emergency Drills to ensure that drill scenarios reflect common actual emergencies and to identify and correct any deficiencies so as to equip staff to be ready for actual emergencies.</li> <li>5. To maintain adequate coverage for all hospital units, the facility recently recruited two new board-certified physicians and surgeons in replacement of physicians who retired.</li> </ol> <p><b>Recommendation 2, March 2010:</b> Ensure that the final meeting of the Mortality Review Committee addresses all recommendations of the external reviewer and that all contributing factors are adequately assessed.</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b> MSH has implemented this recommendation. However, this monitor reviewed the facility's documents and reviews conducted regarding two unexpected mortalities and found evidence of inadequate administrative oversight to ensure that timely and appropriate measures were taken to ensure the safety of other individuals at the facility.</p> <p><b>Other findings:</b> This monitor reviewed the charts of 10 individuals who were transferred to an outside medical facility on 12 occasions during this reporting period. The following table outlines the episodes of transfer review by date of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 708 1883 1354"> <thead> <tr> <th>Individual</th> <th>Date of MD evaluation</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2/2/10</td> <td>Bilateral Pneumonia</td> </tr> <tr> <td>2</td> <td>2/22/10</td> <td>Seizure disorder</td> </tr> <tr> <td>3</td> <td>3/4/10</td> <td>Abdominal Pain</td> </tr> <tr> <td>3</td> <td>3/12/10</td> <td>Recurrent Abdominal Pain</td> </tr> <tr> <td>4</td> <td>3/17/10</td> <td>Bilateral Pneumonia</td> </tr> <tr> <td>2</td> <td>4/1/10</td> <td>Rhabdomyolysis</td> </tr> <tr> <td>5</td> <td>4/6/10</td> <td>Hypoxia, R/O Aspiration Pneumonia, Aplastic Anemia, Acute Necrotizing Gingivitis</td> </tr> <tr> <td>6</td> <td>4/28/10</td> <td>Intestinal Obstruction, Aspiration Pneumonia</td> </tr> <tr> <td>7</td> <td>6/1/10</td> <td>Diabetic Ketoacidosis</td> </tr> <tr> <td>8</td> <td>7/2/10</td> <td>Hypercalcemia</td> </tr> <tr> <td>9</td> <td>7/9/10</td> <td>Seizure disorder</td> </tr> <tr> <td>10</td> <td>7/23/10</td> <td>Dehydration</td> </tr> </tbody> </table> <p>The review found general evidence of timely and adequate medical care.</p>	Individual	Date of MD evaluation	Reason for transfer	1	2/2/10	Bilateral Pneumonia	2	2/22/10	Seizure disorder	3	3/4/10	Abdominal Pain	3	3/12/10	Recurrent Abdominal Pain	4	3/17/10	Bilateral Pneumonia	2	4/1/10	Rhabdomyolysis	5	4/6/10	Hypoxia, R/O Aspiration Pneumonia, Aplastic Anemia, Acute Necrotizing Gingivitis	6	4/28/10	Intestinal Obstruction, Aspiration Pneumonia	7	6/1/10	Diabetic Ketoacidosis	8	7/2/10	Hypercalcemia	9	7/9/10	Seizure disorder	10	7/23/10	Dehydration
Individual	Date of MD evaluation	Reason for transfer																																							
1	2/2/10	Bilateral Pneumonia																																							
2	2/22/10	Seizure disorder																																							
3	3/4/10	Abdominal Pain																																							
3	3/12/10	Recurrent Abdominal Pain																																							
4	3/17/10	Bilateral Pneumonia																																							
2	4/1/10	Rhabdomyolysis																																							
5	4/6/10	Hypoxia, R/O Aspiration Pneumonia, Aplastic Anemia, Acute Necrotizing Gingivitis																																							
6	4/28/10	Intestinal Obstruction, Aspiration Pneumonia																																							
7	6/1/10	Diabetic Ketoacidosis																																							
8	7/2/10	Hypercalcemia																																							
9	7/9/10	Seizure disorder																																							
10	7/23/10	Dehydration																																							

Section F: Specific Therapeutic and Rehabilitation Services

		<p>However, this monitor found a pattern of process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to maintain substantial compliance with this requirement. The following are examples:</p> <ol style="list-style-type: none"> <li>1. The neurological examination of an individual who had experienced a fall (and was lethargic) was inadequate (LW).</li> <li>2. There was no evidence of a functional assessment of an individual who has refused food intake while hospitalized at the facility, which has caused serious medical complications (CW).</li> <li>3. The quarterly medical assessment of an individual (JM) who suffered from Insulin Dependent Diabetes Mellitus (and was intermittently non-compliant with insulin) did not include adequate review of the diabetic status of this individual. This individual was transferred to an outside hospital after developing Diabetic Ketoacidosis.</li> <li>4. There was evidence of inadequate nurse-physician communication that appeared to have resulted in a delay in the transfer of an individual who was diagnosed with Bilateral Pneumonia and HIV positive status during outside hospitalization (RR).</li> </ol> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Implement corrective actions to address the monitor's findings of deficiencies.</li> <li>2. Improve facility administrative oversight to ensure timely and appropriate immediate systemic corrective measures in the context of the initial mortality reviews.</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.

Section F: Specific Therapeutic and Rehabilitation Services

<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 recommendations:</b></p> <p><b>Recommendation 1, March 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 20% of all individuals with at least one diagnosis on Axis III during the review period (February-July 2010):</p> <table border="1" data-bbox="991 597 1885 933"> <tr> <td data-bbox="991 597 1087 673">1.</td> <td data-bbox="1087 597 1795 673"><i>There is a quarterly note that documents reassessment of the individual medical status.</i></td> <td data-bbox="1795 597 1885 673">98%</td> </tr> <tr> <td data-bbox="991 673 1087 750">2.</td> <td data-bbox="1087 673 1795 750"><i>Significant conditions for which the individual is at risk for complications are identified.</i></td> <td data-bbox="1795 673 1885 750">98%</td> </tr> <tr> <td data-bbox="991 750 1087 933">3.</td> <td data-bbox="1087 750 1795 933"><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="1795 750 1885 933">99%</td> </tr> </table> <p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period for all items.</p> <p><b>Recommendation 2, March 2010:</b> Ensure full implementation of the new template for medical quarterly notes.</p> <p><b>Findings:</b> Reviews by this monitor confirmed that MSH has implemented this recommendation.</p>	1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	98%	2.	<i>Significant conditions for which the individual is at risk for complications are identified.</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%
1.	<i>There is a quarterly note that documents reassessment of the individual medical status.</i>	98%									
2.	<i>Significant conditions for which the individual is at risk for complications are identified.</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%									

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Other findings:</b> This monitor reviewed Quarterly Medical Assessment Notes on the following 10 individuals: AD, BJB, GMM, GS, JEK, JR, LG, LT, MO and SE. These notes were randomly selected to represent the practice of different providers. The notes included general evidence of adequate review. Refer to F.7.a for additional findings.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement</p>												
F.7.b.ii	<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 recommendation:</b></p> <p><b>Recommendation, March 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 97% of medical transfers during the review period (February-July 2010):</p> <table border="1" data-bbox="989 1040 1887 1414"> <tr> <td data-bbox="989 1040 1087 1154">1.</td> <td data-bbox="1087 1040 1793 1154"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 1040 1887 1154">95%</td> </tr> <tr> <td data-bbox="989 1154 1087 1308">2.</td> <td data-bbox="1087 1154 1793 1308"><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="1793 1154 1887 1308">94%</td> </tr> <tr> <td data-bbox="989 1308 1087 1382">3.</td> <td data-bbox="1087 1308 1793 1382"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1308 1887 1382">94%</td> </tr> <tr> <td data-bbox="989 1382 1087 1414">4.</td> <td data-bbox="1087 1382 1793 1414"><i>Sufficient information is provided by the external</i></td> <td data-bbox="1793 1382 1887 1414">97%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	95%	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>	94%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	94%	4.	<i>Sufficient information is provided by the external</i>	97%
1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	95%												
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>	94%												
3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	94%												
4.	<i>Sufficient information is provided by the external</i>	97%												

Section F: Specific Therapeutic and Rehabilitation Services

			<i>facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	
		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>	98%
		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>	98%
		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	99%
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period for all items.</p> <p>MSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 21% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (February-July 2010). The following is a summary of the data:</p>				
		1.	<i>All medical conditions listed in Axis III are included on the Medical Conditions form</i>	92%
		2.	<i>The WRP includes a focus statement, objective and intervention for 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%

Section F: Specific Therapeutic and Rehabilitation Services

		5.	<i>There are appropriate intervention(s) for each objective</i>	94%
		6	<i>Each state hospital shall ensure that interdisciplinary teams, review, assess and develop strategies to overcome individuals' refusals of medical procedures</i>	91%
		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>	95%
<p>Comparative data indicated that MSH has maintained a compliance rate of at least 90% since the previous review period for all items.</p> <p>In addition, MSH has provided data on its reviews of the Medical Emergency Response System. Using the DMH Medical Emergency Response MH-C 9128 Form, MSH assessed its compliance based on a sample of 100% of actual medical emergencies (mean number was four) during the review period (February to July 2010):</p>				
		1.	<i>Did the first responder appropriately assess and call for help?</i>	97%
		2.	<i>Did the first responder provide appropriate CPR procedure?</i>	100%
		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
		4.	<i>Did the first responder provide Heimlich procedure?</i>	N/A
		5.	<i>Did the first responder provide appropriate BFA proc?</i>	100%
		6.	<i>Did the Individual suffer any complications?</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>	96%
		9.	<i>Did a sufficient number of staff respond in a</i>	100%

Section F: Specific Therapeutic and Rehabilitation Services

			<i>timeframe?</i>	
		10.	<i>Was the unit milieu appropriately managed?</i>	100%
		11.	<i>Was all required equipment available?</i>	100%
		12.	<i>Was all required equipment in working order?</i>	96%
		13.	<i>Were all medical supplies available?</i>	100%
		14.	<i>Were all medications available?</i>	93%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	97%
		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 EMS able to access the site in a timely manner?</i>	100%
		20.	<i>Was all required documentation completed?</i>	100%
		21.	<i>Was the equipment restocking completed within 8 hours?</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 that were applicable in either period.</p> <p>Using the above-referenced form, MSH also assessed its compliance based on a sample of 100% of medical emergency drills conducted during the review period (February to July 2010):</p>		
		1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
		2.	<i>Did the first responder provide appropriate CPR proc?</i>	100%
		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
		4.	<i>Did the first responder provide Heimlich proc?</i>	100%
		5.	<i>Did the first responder provide appropriate BFA proc?</i>	100%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td>6.</td> <td><i>Did the Individual suffer any complications?</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Did the RN respond in a timeframe consistent with the emergency?</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Did the MD respond within 15 minutes?</i></td> <td>95%</td> </tr> <tr> <td>9.</td> <td><i>Did a sufficient number of staff respond in a timeframe?</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Was the unit milieu appropriately managed?</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Was all required equipment available?</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>Was all required equipment in working order?</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Were all medical supplies available?</i></td> <td>100%</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>98%</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 EMS able to access the site in a timely manner?</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>Was all required documentation completed?</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> <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>	6.	<i>Did the Individual suffer any complications?</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>	95%	9.	<i>Did a sufficient number of staff respond in a timeframe?</i>	100%	10.	<i>Was the unit milieu appropriately managed?</i>	100%	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>	98%	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 EMS able to access the site in a timely manner?</i>	100%	20.	<i>Was all required documentation completed?</i>	100%	21.	<i>Was the equipment restocking completed within 8 hours?</i>	98%
6.	<i>Did the Individual suffer any complications?</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>	95%																																																
9.	<i>Did a sufficient number of staff respond in a timeframe?</i>	100%																																																
10.	<i>Was the unit milieu appropriately managed?</i>	100%																																																
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>	98%																																																
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 EMS able to access the site in a timely manner?</i>	100%																																																
20.	<i>Was all required documentation completed?</i>	100%																																																
21.	<i>Was the equipment restocking completed within 8 hours?</i>	98%																																																
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<b>Current findings on previous recommendation:</b>																																																

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH has continued its practice.</p> <p><b>Other findings:</b> Refer to F.7.a for review of new procedures developed during this reporting period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.iv	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> MSH has continued its practice as confirmed by this monitor's review of the schedule of after-hours physician coverage during this review period.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.7.b.v	<p>endeavor to obtain, on a consistent and timely basis, an individual's medical records after the</p>	<p><b>Current findings on previous recommendation:</b></p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>individual is treated in another medical facility.</p>	<p><b>Recommendation, March 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 100% sample of individuals returning from outside medical treatment during the review period (February-July 2010), tracking 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%, compared to 81% during the last review period.</p> <p><b>Other findings:</b> This monitor's chart reviews (see F.7.a) found evidence of required records from outside medical facilities in all cases.</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, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> MSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and</p>

Section F: Specific Therapeutic and Rehabilitation Services

asthma/COPD. The average samples ranged from 20% to 21% of individuals diagnosed with these disorders during the review months (February-July 2010). 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>	93%
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>	97%
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%
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%

Section F: Specific Therapeutic and Rehabilitation Services

		<p><u>Hypertension</u></p> <table border="1"> <tr> <td data-bbox="989 305 1087 378">1.</td> <td data-bbox="1087 305 1793 378"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 305 1887 378">100%</td> </tr> <tr> <td data-bbox="989 378 1087 418">2.</td> <td data-bbox="1087 378 1793 418"><i>Blood pressure is monitored weekly.</i></td> <td data-bbox="1793 378 1887 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 532">3.</td> <td data-bbox="1087 418 1793 532"><i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i></td> <td data-bbox="1793 418 1887 532">100%</td> </tr> <tr> <td data-bbox="989 532 1087 605">4.</td> <td data-bbox="1087 532 1793 605"><i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i></td> <td data-bbox="1793 532 1887 605">93%</td> </tr> <tr> <td data-bbox="989 605 1087 646">5.</td> <td data-bbox="1087 605 1793 646"><i>Hypertension is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 605 1887 646">100%</td> </tr> <tr> <td data-bbox="989 646 1087 719">6.</td> <td data-bbox="1087 646 1793 719"><i>Focus 6 for Hypertension has appropriate objectives and interventions.</i></td> <td data-bbox="1793 646 1887 719">100%</td> </tr> <tr> <td data-bbox="989 719 1087 792">7.</td> <td data-bbox="1087 719 1793 792"><i>A dietary consult was considered and the recommendation was followed, as applicable.</i></td> <td data-bbox="1793 719 1887 792">100%</td> </tr> <tr> <td data-bbox="989 792 1087 946">8.</td> <td data-bbox="1087 792 1793 946"><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></td> <td data-bbox="1793 792 1887 946">100%</td> </tr> <tr> <td data-bbox="989 946 1087 987">9.</td> <td data-bbox="1087 946 1793 987"><i>An exercise program has been initiated.</i></td> <td data-bbox="1793 946 1887 987">100%</td> </tr> <tr> <td data-bbox="989 987 1087 1060">10.</td> <td data-bbox="1087 987 1793 1060"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1793 987 1887 1060">100%</td> </tr> </table> <p><u>Dyslipidemia</u></p> <table border="1"> <tr> <td data-bbox="989 1170 1087 1243">1.</td> <td data-bbox="1087 1170 1793 1243"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 1170 1887 1243">100%</td> </tr> <tr> <td data-bbox="989 1243 1087 1284">2.</td> <td data-bbox="1087 1243 1793 1284"><i>A lipid panel was ordered at least quarterly.</i></td> <td data-bbox="1793 1243 1887 1284">100%</td> </tr> <tr> <td data-bbox="989 1284 1087 1357">3.</td> <td data-bbox="1087 1284 1793 1357"><i>The HDL level is &gt;40(M) or &gt;50(F) or a plan of care is in place.</i></td> <td data-bbox="1793 1284 1887 1357">100%</td> </tr> <tr> <td data-bbox="989 1357 1087 1398">4.</td> <td data-bbox="1087 1357 1793 1398"><i>The LDL level is ≤ 130 or a plan of care is in place.</i></td> <td data-bbox="1793 1357 1887 1398">94%</td> </tr> </table>	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>	100%	4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	93%	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%	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>	94%
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>	100%																																										
4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	93%																																										
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%																																										
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>	94%																																										

Section F: Specific Therapeutic and Rehabilitation Services

		5.	<i>The Triglyceride level is <math>\leq</math> 200 of a plan of care is in place.</i>	95%
		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%
		<u>Asthma/COPD</u>		
		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%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 188 1087 305">8.</td> <td data-bbox="1087 188 1793 305"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1793 188 1894 305">100%</td> </tr> </table>	8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	100%																					
8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	100%																								
<p>In addition, MSH conducted audits to assess Cardiac Disease (n=23, sample size unspecified) and Preventive Care (100% sample) 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>																										
<table border="1"> <tr> <td data-bbox="989 597 1087 673">1.</td> <td data-bbox="1087 597 1793 673"><i>Did the patient receive CAD symptom and activity assessment?</i></td> <td data-bbox="1793 597 1894 673">100%</td> </tr> <tr> <td data-bbox="989 673 1087 750">2.</td> <td data-bbox="1087 673 1793 750"><i>Did the patient receive at least one lipid profile in last year?</i></td> <td data-bbox="1793 673 1894 750">100%</td> </tr> <tr> <td data-bbox="989 750 1087 826">3.</td> <td data-bbox="1087 750 1793 826"><i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i></td> <td data-bbox="1793 750 1894 826">100%</td> </tr> <tr> <td data-bbox="989 826 1087 865">4.</td> <td data-bbox="1087 826 1793 865"><i>Does the patient have a LDL-C level &lt;130mg/dl?</i></td> <td data-bbox="1793 826 1894 865">95%</td> </tr> <tr> <td data-bbox="989 865 1087 904">5.</td> <td data-bbox="1087 865 1793 904"><i>Does the patient have a LDL-C &lt;100mg/dl?</i></td> <td data-bbox="1793 865 1894 904">84%</td> </tr> <tr> <td data-bbox="989 904 1087 943">6.</td> <td data-bbox="1087 904 1793 943"><i>Was antiplatelet therapy prescribed?</i></td> <td data-bbox="1793 904 1894 943">100%</td> </tr> <tr> <td data-bbox="989 943 1087 1019">7.</td> <td data-bbox="1087 943 1793 1019"><i>Was beta blocker prescribed after MI or contraindication documented?</i></td> <td data-bbox="1793 943 1894 1019">100%</td> </tr> <tr> <td data-bbox="989 1019 1087 1057">8.</td> <td data-bbox="1087 1019 1793 1057"><i>Was ACE inhibitor (or ARB) prescribed?</i></td> <td data-bbox="1793 1019 1894 1057">93%</td> </tr> </table>			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.	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	100%	4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	95%	5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	84%	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>	93%
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.	<i>Did the patient receive lipid-lowering therapy for anyone with LDL &gt; 100?</i>	100%																								
4.	<i>Does the patient have a LDL-C level &lt;130mg/dl?</i>	95%																								
5.	<i>Does the patient have a LDL-C &lt;100mg/dl?</i>	84%																								
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>	93%																								
<p><u>Preventive Care</u></p>																										
<table border="1"> <tr> <td data-bbox="989 1166 1087 1425">1.</td> <td data-bbox="1087 1166 1793 1425"><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</i></td> <td data-bbox="1793 1166 1894 1425">100%</td> </tr> </table>			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</i>	100%																					
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</i>	100%																								

Section F: Specific Therapeutic and Rehabilitation Services

			<i>discussion of smoking cessation strategies?</i>	
		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>	99%
		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>	98%
		4	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)	96%
		5.	If the individual is 65 or older, has a Pneumonia vaccine been offered or is there documentation that the individual has previously had one, as documented on the Preventive Care Tracking Form?	100%
		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 51 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:</i> <i>(1) fecal occult blood test during the past year,</i> <i>(2) flexible sigmoidoscopy during the past four</i>	97%

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 188 1087 337"></td> <td data-bbox="1087 188 1795 337"> <p><i>years,</i></p> <p>(3) double contrast barium enema during the past four years or</p> <p>(4) colonoscopy during the past nine years?</p> </td> <td data-bbox="1795 188 1890 337"></td> </tr> <tr> <td data-bbox="989 337 1087 451">8.</td> <td data-bbox="1087 337 1795 451"> <p><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></p> </td> <td data-bbox="1795 337 1890 451">100%</td> </tr> <tr> <td data-bbox="989 451 1087 602">9.</td> <td data-bbox="1087 451 1795 602"> <p><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></p> </td> <td data-bbox="1795 451 1890 602">99%</td> </tr> <tr> <td data-bbox="989 602 1087 753">9.</td> <td data-bbox="1087 602 1795 753"> <p><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></p> </td> <td data-bbox="1795 602 1890 753">100%</td> </tr> </table> <p>Comparative data for all of the above-mentioned tools indicated that the facility has maintained compliance rates of at least 90% since the last review period for all items with the exception of item 5 on the Cardiac Disease Audit.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<p><i>years,</i></p> <p>(3) double contrast barium enema during the past four years or</p> <p>(4) colonoscopy during the past nine years?</p>		8.	<p><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></p>	100%	9.	<p><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></p>	99%	9.	<p><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></p>	100%
	<p><i>years,</i></p> <p>(3) double contrast barium enema during the past four years or</p> <p>(4) colonoscopy during the past nine years?</p>													
8.	<p><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></p>	100%												
9.	<p><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></p>	99%												
9.	<p><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></p>	100%												
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>Recommendation 1, March 2010:</b> Provide summary regarding status of implementation of the reprivileging process.</p>												

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b>  The facility reported the following indicators that are used by the Department of Medicine in the Ongoing Physician Performance Evaluations for the purpose of privileging/re-privileging of physicians:</p> <ol style="list-style-type: none"> <li>1. Admission, Quarterly and Annual Assessments are completed in a timely manner including neurological exams, breast exams, rectal exams and Pap smears as clinically indicated;</li> <li>2. Diagnostic work-up completed (or ordered) as clinically indicated and results reviewed and monitored in a timely manner for every medical condition;</li> <li>3. Diagnoses for all medical conditions, acute and chronic, are accurate and supported by clinical and laboratory findings;</li> <li>4. Formulation of treatment plans regarding medical conditions;</li> <li>5. Care provided is according to established standards and hospital policies including consultations and transfers. The following conditions are selected as standard indicators of care; HTN, Diabetes, Asthma/COPD, Fractures, PICA, Seizure Disorders, Pneumonia and Other Infections;</li> <li>6. Incomplete exams, laboratory studies or refusals are addressed including referral to the WRPT for inclusion in the treatment plan;</li> <li>7. Committee attendance;</li> <li>8. Completion of required Continuing Medical Education;</li> <li>9. Medical Emergency Response evaluations (if applicable);</li> <li>10. Utilization of medications (narcotics, drug-drug interactions);</li> <li>11. Clinical Pharmacy Reviews; and</li> <li>12. Assessment, documentation and follow-up on recommendations for acute inter-facility transfers.</li> </ol> <p>In addition, the facility reported that focused Physician Performance Evaluations are conducted when indicated.</p> <p>The compiled performance evaluation from quarterly reviews is utilized</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>by the Chief Physician and Surgeon to make recommendations for privileging/re-privileging, which are due every two years according to MSH Medical Staff Bylaws.</p> <p>Of the eight Physicians and Surgeons eligible for reprivileging between August 1, 2009 and July 31, 2010, all eight were repriviledged (100%). This number represents 33.3% of the 24 Physicians and Surgeons in the Department of Medicine. In addition, five physicians were privileged for the first time during the same period but they are not included in the above percentage.</p> <p>This monitor found evidence of occasional but serious deficiencies in the implementation of the current system of reassessing the performance of practitioners in special situations. This was evident in the failure of the facility leadership to conduct, in a timely and adequate manner, a peer review as an immediate measure to ensure the safety of individuals following the occurrence of critical medical events that raised questions of possible negligence.</p> <p><b>Recommendation 2, March 2010:</b> Continue to update practice guidelines guided by current literature and relevant clinical experience.</p> <p><b>Findings:</b> MSH has developed guidelines regarding the management of Viral Hepatitis and Elevated Lipase/Amylase. These guidelines were presented by the Chief of Medical Education and the Chief Physician and Surgeon during the regular CME physicians' conferences. The facility installed the UP-TO-DATE web site and it is available for all physicians to maintain access to new literature and clinical guidelines.</p> <p><b>Recommendation 3, September 2009:</b> Provide peer review data analysis regarding practitioner and group</p>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

		<p>trends, with corrective actions as indicated.</p> <p><b>Findings:</b> MSH presented the following peer review aggregated data:</p> <table border="1" data-bbox="991 375 1887 678"> <tr> <td data-bbox="991 375 1087 451">1.</td> <td data-bbox="1087 375 1793 451"><i>Was an appropriate medical (acute/chronic) condition and treatment addressed and documented?</i></td> <td data-bbox="1793 375 1887 451">100%</td> </tr> <tr> <td data-bbox="991 451 1087 527">2.</td> <td data-bbox="1087 451 1793 527"><i>Was an appropriate diagnostic and medical work up (lab, X-Ray, consultation, etc.) done and monitored?</i></td> <td data-bbox="1793 451 1887 527">100%</td> </tr> <tr> <td data-bbox="991 527 1087 604">3.</td> <td data-bbox="1087 527 1793 604"><i>Was medical care adequate and appropriate as recommended by the medical society?</i></td> <td data-bbox="1793 527 1887 604">100%</td> </tr> <tr> <td data-bbox="991 604 1087 678">4.</td> <td data-bbox="1087 604 1793 678"><i>Has the admission/annual physical exam been completed?</i></td> <td data-bbox="1793 604 1887 678">96%</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><b>Recommendation 4, September 2009:</b> Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions as indicated.</p> <p><b>Findings:</b> MSH presented process and clinical outcome data based on the following indicators. In general, the data demonstrated that the facility has maintained positive outcomes. The following is a summary outline of the indicators:</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 new diagnoses of Diabetes Mellitus in individuals receiving 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> </ol> </li> </ol>	1.	<i>Was an appropriate medical (acute/chronic) condition and treatment addressed and documented?</i>	100%	2.	<i>Was an appropriate diagnostic and medical work up (lab, X-Ray, consultation, etc.) done and monitored?</i>	100%	3.	<i>Was medical care adequate and appropriate as recommended by the medical society?</i>	100%	4.	<i>Has the admission/annual physical exam been completed?</i>	96%
1.	<i>Was an appropriate medical (acute/chronic) condition and treatment addressed and documented?</i>	100%												
2.	<i>Was an appropriate diagnostic and medical work up (lab, X-Ray, consultation, etc.) done and monitored?</i>	100%												
3.	<i>Was medical care adequate and appropriate as recommended by the medical society?</i>	100%												
4.	<i>Has the admission/annual physical exam been completed?</i>	96%												

Section F: Specific Therapeutic and Rehabilitation Services

		<ul style="list-style-type: none"> <li>e. Percentage of individuals whose BMI is tracked monthly</li> <li>f. Compliance with the inclusion of WRP objectives and interventions for Constipation</li> <li>g. Number of individuals with 3+ falls in 30 days</li> <li>h. Total number of falls</li> <li>i. Timeliness and appropriateness of external consultations</li> <li>j. Review process for unexpected deaths</li> <li>k. Number of individuals receiving Clozaril</li> </ul> <p>2. Clinical outcomes tracked:</p> <ul style="list-style-type: none"> <li>a. HA1c readings for individuals with Diabetes Mellitus</li> <li>b. HA1c readings for all individuals with Diabetes Mellitus who also receive new generation antipsychotics</li> <li>c. Average body mass index of individuals with BMI &gt;25</li> <li>d. Percentage of individuals with Hypertension with blood pressure &lt;140/90</li> <li>e. Percentage of individuals with Diabetes Mellitus with blood pressure &lt;130/80</li> <li>f. Number of individuals hospitalized for Bowel Dysfunction</li> <li>g. Individuals with falls with major injury</li> <li>h. Number of individuals diagnosed with Aspiration Pneumonia</li> <li>i. Number of individuals with refractory seizures</li> <li>j. Number of individuals with status epilepticus</li> <li>k. 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> Partial.</p> <p><b>Current recommendations:</b></p> <ul style="list-style-type: none"> <li>1. Provide summary regarding status of implementation of the</li> </ul>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		<p>reprivileging process, including specific information about the performance indicators and percentage of providers who were reassessed using these indicators.</p> <ol style="list-style-type: none"><li>2. Continue to update practice guidelines guided by current literature and relevant clinical experience.</li><li>3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated.</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></ol>
--	--	--

Section F: Specific Therapeutic and Rehabilitation Services

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. Cindy Lusch, RN, Acting Nursing Administrator</li> <li>2. Dennis Lim, RN</li> <li>3. Linda Gross, RN, Nursing Coordinator, CNS</li> <li>4. Loraine Clinton, PHN</li> <li>5. Zakaria Boshra, MD</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH's progress report and data</li> <li>2. Infection Control Committee meeting minutes dated 5/26/10 and 6/23/10</li> <li>3. Medical Executive Committee meeting minutes dated 3/15/10, 3/23/10, 4/19/10, 4/27/10, 5/17/10, 6/21/10, 7/19/10 and 7/20/10</li> <li>4. Nurse Executive Council meeting minutes dated 4/7/10, 4/16/10, 4/21/10, 4/28/10, 5/5/10, 5/26/10, 6/2/10, 6/9/10, 6/16/10, 6/23/10, 6/30/10, 7/7/10, 7/14/10, 7/21/10 and 7/28/10</li> <li>5. Common Myths about the Flu among Health Care Workers</li> <li>6. Treatment of Latent Tuberculosis Infection (February 2010)</li> <li>7. Medical records for the following 75 individuals: ACB, ACR, ADL, AE, AM, AMM, ARM, ASG, BJB, CC, CED, CG, CKD, CLH, CM, CMM, CMP, CP, DAM, DBC, DCM, DGB, DLM, DLW, DRM, DS, EAH, EDM, EE, ELC, FR, FVS, GC, JAR, JAS, JC, JE, JEF, JES, JI, JJZ, JOA, JS, JZC, KDP, KM, LAP, LDH, LLF, LO, MMS, MW, PMS, PWC, RB, RC, RCF, RKV, RLF, RNJ, RR, RRD, RRT, SAS, SG, SH, SKC, SRM, SS, TJB, TL, TLB, VC, VX and WO</li> </ol>
<p>F.8.a</p>	<p>Each State hospital shall establish an effective infection control program that:</p>	<p><b>Compliance:</b> Substantial.</p>

Section F: Specific Therapeutic and Rehabilitation Services

<p>F.8.a.i</p>	<p>actively collects data regarding infections and communicable diseases;</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Ensure that there is appropriate documentation of physician's evaluation for individuals with positive PPDs.</li> <li>• Ensure that WRPs are individualized, with appropriate objectives and interventions.</li> </ul> <p><b>Findings:</b> Since the last review, there has been regular consultation and mentoring between the Nursing Coordinators, HSSs, and the Nurse Administrator to provide mentoring to the unit level RNs regarding writing individualized WRPs. In addition, the PHNs participate in the weekly NEC meetings addressing IC issues.</p> <p><b>Recommendation 3, March 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 24% of individuals admitted to the hospital with a negative PPD in the review months (February-July 2010):</p> <table border="1" data-bbox="991 1117 1890 1416"> <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> </table>	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%
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%												

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 190 1079 266">5.</td> <td data-bbox="1079 190 1793 266"><i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 190 1898 266">100%</td> </tr> </table>	5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</i>	100%							
5.	<i>2<sup>nd</sup> step PPDs were read by the nurse within 48-72 hours of administration.</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><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 20 individuals admitted during the review period (ACR, AM, ARM, ASG, CC, CED, CKD, CM, CMP, EAH, EE, JAS, JI, JJZ, PMS, RB, RC, SH, VX and WO) found that all had a physician's order for PPD upon admission and all PPDs 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 24% of individuals needing an annual PPD during the review months (February-July 2010):</p>												
<table border="1"> <tr> <td data-bbox="989 1224 1079 1305">1.</td> <td data-bbox="1079 1224 1793 1305"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 1224 1898 1305">100%</td> </tr> <tr> <td data-bbox="989 1305 1079 1386">2.</td> <td data-bbox="1079 1305 1793 1386"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 1305 1898 1386">100%</td> </tr> <tr> <td data-bbox="989 1386 1079 1414">3.</td> <td data-bbox="1079 1386 1793 1414"><i>PPDs were administered by the nurse within 24 hours</i></td> <td data-bbox="1793 1386 1898 1414">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</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</i>	100%										

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="989 191 1087 228"></td> <td data-bbox="1087 191 1795 228"><i>of the order.</i></td> <td data-bbox="1795 191 1894 228"></td> </tr> <tr> <td data-bbox="989 228 1087 305">4.</td> <td data-bbox="1087 228 1795 305"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1795 228 1894 305">100%</td> </tr> </table>		<i>of the order.</i>		4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	100%
	<i>of the order.</i>							
4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</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><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 20 individuals requiring an annual PPD during the review period (ACB, AE, AMM, BJB, DCM, DS, EDM, FVS, JAR, JES, JZC, KDP, LAP, LLF, RLF, RNJ, RRT, SKC, TJB and VC) 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 40% of individuals admitted to the hospital in the review months (February-July 2010) who were positive for Hepatitis C:</p>								
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		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>	100%
		3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%
		4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	82%
		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 all items except item 4, which was 86% in the previous period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> The medical consultants assigned to the admission units were not consistently documenting the evaluation of the individual's medication plan and immunizations for Hepatitis A and B (item 4).</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> A collaborative review of the above was implemented between the chief physician and surgeon, the chairperson of the Infection Control Committee, PHN, and nursing administration to address and correct the inconsistencies found pertaining to item 4.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> In-services were provided to all Medical Consultants regarding medication precautions in individuals with Hepatitis C. Also, beginning in July 2010,</p>				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the Program HSSs are involved in follow-up and monitoring of this issue.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> Nursing administration will continue to provide audit results to the chief physician and surgeon.</p> <p>A review of the records of nine individuals who were admitted Hepatitis C positive during the review period (CP, DBC, JC, JE, JOA, LO, PWC, RKV and SAS) found that eight 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 100% sample (five individuals) of individuals who were positive for HIV antibody in the review months (February-July 2010):</p> <table border="1" data-bbox="989 857 1890 1416"> <tr> <td data-bbox="989 857 1087 971">1.</td> <td data-bbox="1087 857 1793 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="1793 857 1890 971">100%</td> </tr> <tr> <td data-bbox="989 971 1087 1084">2.</td> <td data-bbox="1087 971 1793 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="1793 971 1890 1084">100%</td> </tr> <tr> <td data-bbox="989 1084 1087 1198">3.</td> <td data-bbox="1087 1084 1793 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="1793 1084 1890 1198">100%</td> </tr> <tr> <td data-bbox="989 1198 1087 1312">4.</td> <td data-bbox="1087 1198 1793 1312"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 1198 1890 1312">N/A</td> </tr> <tr> <td data-bbox="989 1312 1087 1416">5.</td> <td data-bbox="1087 1312 1793 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="1793 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%															

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td></td> <td><i>another timeframe is ordered by the physician.</i></td> <td></td> </tr> <tr> <td>6.</td> <td><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate objective is written to address the progression of the disease.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Appropriate interventions are written.</i></td> <td>100%</td> </tr> </table>		<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%	
	<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 that were not N/A in either 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 five individuals who were admitted during the review period with HIV (CLH, CP, EE, RR and SG) found that all were in compliance regarding clinic referrals and follow-up, and four WRPs contained appropriate objectives and/or interventions. The one WRP that was not adequate (CP) was modified during the review to include appropriate objectives and interventions.</p> <p><b><u>Immunizations</u></b> Using the DMH IC Immunization Audit, MSH assessed its compliance based on an average sample of 21% of individuals admitted to the hospital during the review months (February-July 2010):</p>													

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1"> <tr> <td data-bbox="976 186 1087 305">1.</td> <td data-bbox="1087 186 1793 305"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 186 1923 305">100%</td> </tr> <tr> <td data-bbox="976 305 1087 378">2.</td> <td data-bbox="1087 305 1793 378"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 305 1923 378">100%</td> </tr> <tr> <td data-bbox="976 378 1087 456">3.</td> <td data-bbox="1087 378 1793 456"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 378 1923 456">89%</td> </tr> <tr> <td data-bbox="976 456 1087 566">4.</td> <td data-bbox="1087 456 1793 566"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 456 1923 566">100%</td> </tr> </table> <p data-bbox="976 609 1923 716">Comparative data indicated that MSH has maintained a compliance rate of at least 90% from the previous review period for items 1, 2 4; item 3 was 97% in the previous period.</p> <p data-bbox="976 760 1923 898"><u>F.8.a.ii: Assesses these data for trends</u> A breakdown in communication was found between the unit psychiatrist and the medical consultant regarding the lab work addressing immunizations.</p> <p data-bbox="976 941 1923 1079"><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> Collaboration was initiated between the PHN/ICLN, nursing administration, and the chief physician and surgeon to address the deficiencies identified for item 3.</p> <p data-bbox="976 1123 1923 1304"><u>F.8.a.iv: Identifies necessary corrective action</u> The unit RNs will address lab results with the assigned medical consultant (and use the Sick Call Log) regarding immunizations. The data will be reviewed monthly by the NEC and the chief physician and surgeon will be notified of any ongoing deficiencies.</p> <p data-bbox="976 1347 1923 1416"><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> MSH will continue to monitor this requirement.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	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>	89%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%												
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>	89%												
4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	100%												

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of 20 individuals (ACR, AM, ARM, ASG, CC, CED, CKD, CM, CMP, EAH, EE, JAS, JI, JJZ, PMS, RB, RC, SH, VX and WO) found that 19 contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and 19 ordered immunizations were timely administered.</p> <p><b><u>Immunization Refusals</u></b>          MSH had no individuals who refused to take their immunizations during the review months (February-July 2010). The IC staff reported that some individuals initially refused; however, the IC Liaison Nurse who administers and tracks the facility's immunizations was successful in working with these individuals to facilitate compliance.</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><b><u>MRSA</u></b>          Using the DMH IC MRSA Audit, MSH assessed its compliance based on a 100% sample (ten individuals) of individuals in the hospital who tested positive for MRSA during the review months (February-July 2010):</p> <table border="1" data-bbox="991 1338 1890 1409"> <tr> <td data-bbox="991 1338 1087 1409">1.</td> <td data-bbox="1087 1338 1795 1409"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive</i></td> <td data-bbox="1795 1338 1890 1409">100%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive</i>	100%
1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive</i>	100%			

Section F: Specific Therapeutic and Rehabilitation Services

			<i>culture for MRSA.</i>	
		2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	90%
		3.	<i>The individual is placed on contact precautions per MRSA policy.</i>	100%
		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 provides MRSA protocol and guidance for the care of the individual.</i>	100%
		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% from the previous review period for all items except for item 3, which increased from 33% to 100%.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> There were no cases of MRSA for the month of May 2010.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> In-services and education was provided by the PHNs for the unit staff regarding the initiation of contact precautions when appropriate, which increased the mean compliance rate for item 3 from 33% to 100%.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> See above.</p>		

Section F: Specific Therapeutic and Rehabilitation Services

		<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 ten individuals with MRSA (ADL, DAM, DGB, DLM, FR, JEF, JS, KM, RCF and SRM) found that three individuals were placed on contact precautions (JS, KM and SRM). Four records contained orders for "MRSA precautions" (ADL, DGB, DLM and RCF); however, the facility does not have a protocol for MRSA precautions. Three records contained no order for contact precaution (DAM, FR, and JEF). All individuals were placed on the appropriate antibiotic; and eight 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 based on an average sample of 33% of individuals in the hospital who had a positive PPD test during the review months (February-July 2010):</p> <table border="1" data-bbox="991 820 1890 1388"> <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>100%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>100%</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>100%</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>100%</td> </tr> </table>	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>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	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>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%
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>	100%																					
3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%																					
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>	100%																					
7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%																					

Section F: Specific Therapeutic and Rehabilitation Services

		<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 11 individuals who had a positive PPD (AE, DLW, DRM, LDH, MMS, MW, RC, RC, RRD, SS and TL) found that all individuals had the required chest x-rays; seven 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 66% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (February-July 2010):</p> <table border="1" data-bbox="989 1263 1890 1409"> <tr> <td data-bbox="989 1263 1087 1409">1.</td> <td data-bbox="1087 1263 1793 1409"><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 1263 1890 1409">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%
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%			

Section F: Specific Therapeutic and Rehabilitation Services

		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%
<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 seven individuals who refused admitting or annual labs/diagnostics (CC, CG, CMM, ELC, GC, SH and TLB) found that two individuals did take their PPDs and the other five 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 in the hospital who tested positive for an STD during the review months (February-July 2010):</p>				

Section F: Specific Therapeutic and Rehabilitation Services

		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 upon admission.</i>	100%
		5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%
		6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	100%
		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 6 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>				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>A review of the records of five individuals with diagnosed STDs (CLH, CP, EE, RR and SG) found that the appropriate lab work indicating a positive STD was obtained in all cases and the STD was adequately addressed in the WRP in all cases.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>
F.8.a.ii	assesses these data for trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p> <p><b>Other findings:</b> MSH's key indicator data from the facility accurately reflected the infection control trends.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iii	initiates inquiries regarding problematic trends;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Findings:</b> See F.8.a.i.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 current practice.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> See F.8.a.i.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
F.8.a.vi	<p>integrates this information into each State hospital's quality assurance review.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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. Additional areas addressed by Infection Control noted in meeting minutes included:</p> <ul style="list-style-type: none"> <li>• The protocol for TB and PPDs has been revised so that the assigned medical consultants are responsible for the initial review and follow-up, with a secondary level of review conducted by the appropriate clinic.</li> <li>• MSH's Nursing Department has provided additional mentorship regarding RN documentation related to IC issues.</li> <li>• The PHNs are regularly attending the weekly NEC meetings.</li> <li>• Infection Control has implemented focused projects for urinary tract infections and catheter use and food-borne pathogens.</li> <li>• IC curriculum was revised to include a review of new transmission-based policies.</li> <li>• MSH is currently developing the 2010 flu campaign and has prepared a form addressing common myths about the flu among health care workers.</li> </ul>

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

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> Toni Nguyen, DDS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH's progress report and data</li> <li>2. Dental appointment log</li> <li>3. Medical records for the following 143 individuals: AC, ACB, AE, AKD, AM, AMA, AML, AMM, AW, BJB, BPL, BS, BWT, BY, CBI, CC, CHL, CMM, CRG, DCM, DEJ, DJP, DOA, DOM, DPR, DS, DWN, EDM, EFL, ELC, FPR, FSG, FVS, GA, GAG, GEB, GER, GG, GGL, GLL, GMS, GRL, GW, HDC, HLO, HMT, HRR, IH, JAM, JAR, JCC, JDH, JEP, JES, JFA, JHM, JJS, JK, JLW, JM, JMB, JMC, JMM, JOA, JOI, JUS, JZC, KDD, KDG, KDP, KIG, KO, KSD, LAC, LAP, LAS, LDM, LG, LJO, LLF, LMG, LUJ, MAA, MBR, MC, MCF, MEB, MES, MHC, MJP, MKN, MOA, MS, MSN, MWS, NA, NAA, NCF, NM, NOK, OAR, OMA, PAL, PGH, POG, PPC, PWC, RBP, RHJ, RJA, RJT, RLF, RLL, RMR, RNJ, ROL, RP, RRT, RU, RUG, RV, SB, SCG, SGP, SGR, SIO, SKC, SRV, STG, SV, TAB, TB, TG, TJB, TL, TLB, TLP, TO, TYB, VAC, VC, VES, WEO and ZDS</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> No new staff have been added to MSH's Dental Department since the last review. This reviewer's findings for this section indicated that the facility has an adequate number of dentists to provide timely and adequate dental care and treatment.</p>

Section F: Specific Therapeutic and Rehabilitation Services

		<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, March 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 (February-July 2010):</p> <table border="1" data-bbox="989 933 1892 976"> <tr> <td>1.a</td> <td><i>Comprehensive dental exam was completed</i></td> <td>99%</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 26 individuals (AKD, BPL, BS, BY, CC, JK, JM, JOA, KDD, KDG, KSD, LG, MES, MHC, MOA, MS, PWC, RP, RV, SB, SGP, SV, TG, TL, TLB and TLP) found 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 (February-July 2010):</p>	1.a	<i>Comprehensive dental exam was completed</i>	99%
1.a	<i>Comprehensive dental exam was completed</i>	99%			

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="989 228 1890 267"> <tr> <td data-bbox="989 228 1087 267">1.b</td> <td data-bbox="1087 228 1793 267"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 228 1890 267">99%</td> </tr> </table> <p data-bbox="989 310 1890 378">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 420 1890 560">A review of the records of 26 individuals (AKD, BPL, BS, BY, CC, JK, JM, JOA, KDD, KDG, KSD, LG, MES, MHC, MOA, MS, PWC, RP, RV, SB, SGP, SV, TG, TL, TLB and TLP) found that all individuals were timely seen for their admission exams.</p> <p data-bbox="989 602 1890 711">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 (February-July 2010):</p> <table border="1" data-bbox="989 748 1890 824"> <tr> <td data-bbox="989 748 1087 824">1.c</td> <td data-bbox="1087 748 1793 824"><i>Annual date of examination was within anniversary month of admission</i></td> <td data-bbox="1793 748 1890 824">99%</td> </tr> </table> <p data-bbox="989 867 1890 935">Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 977 1890 1086">A review of the records of 20 individuals (ACB, AE, AMM, BJB, DCM, DS, EDM, FVS, JAR, JES, JZC, KDP, LAP, LLF, RLF, RNJ, RRT, SKC, TJB and VC) found that all annual exams were timely completed.</p> <p data-bbox="989 1128 1890 1268">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 (February-July 2010):</p> <table border="1" data-bbox="989 1305 1890 1417"> <tr> <td data-bbox="989 1305 1087 1417">1.d</td> <td data-bbox="1087 1305 1793 1417"><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="1793 1305 1890 1417">96%</td> </tr> </table>	1.b	<i>If admission examination date was 90 days or less</i>	99%	1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%	1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	96%
1.b	<i>If admission examination date was 90 days or less</i>	99%									
1.c	<i>Annual date of examination was within anniversary month of admission</i>	99%									
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	96%									

Section F: Specific Therapeutic and Rehabilitation Services

		<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 46 individuals (ACB, AE, AKD, AMM, BJB, BPL, BS, BY, CC, DCM, DS, EDM, FVS, JAR, JES, JK, JM, JOA, JZC, KDD, KDG, KDP, KSD, LAP, LG, LLF, MES, MHC, MOA, MS, PWC, RLF, RNJ, RP, RRT, RV, SB, SGP, SKC, SV, TG, TJB, TL, TLB, TLP and VC) found that 44 individuals were timely seen for follow-up care.</p> <p>Using the DMH Dental Services Audit, MSH assessed its compliance based on a 100% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (February-July 2010):</p> <table border="1" data-bbox="991 743 1890 896"> <tr> <td data-bbox="991 743 1087 896">1.e</td> <td data-bbox="1087 743 1795 896"><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 743 1890 896">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 15 individuals (CHL, DEJ, EDM, EFL, GG, GLL, JDH, JEP, KDG, KO, LJO, MJP, NOK, PAL and POG) 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:	<b>Current findings on previous recommendation:</b>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p><b>Recommendation, March 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 20% mean sample of individuals scheduled for follow-up dental care during the review months (February-July 2010):</p> <table border="1" data-bbox="993 488 1892 602"> <tr> <td data-bbox="993 488 1087 602">2.</td> <td data-bbox="1087 488 1795 602"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1795 488 1892 602">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 dental documentation for 46 individuals (ACB, AE, AKD, AMM, BJB, BPL, BS, BY, CC, DCM, DS, EDM, FVS, JAR, JES, JK, JM, JOA, JZC, KDD, KDG, KDP, KSD, LAP, LG, LLF, MES, MHC, MOA, MS, PWC, RLF, RNJ, RP, RRT, RV, SB, SGP, SKC, SV, TG, TJB, TL, TLB, TLP and VC) found compliance with the documentation requirements in all cases.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%
2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	100%			
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, March 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</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>examinations during the review months (February-July 2010):</p> <table border="1" data-bbox="991 266 1887 378"> <tr> <td data-bbox="991 266 1087 378">3.a</td> <td data-bbox="1087 266 1793 378"><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 266 1887 378">99%</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 20 individuals (AML, CRG, DOA, GRL, HRR, JAR, JCC, JLW, KIG, LAC, MAA, MKN, MSN, OMA, RMR, ROL, SGR, SIO, STG and VES) found that all 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 (February-July 2010):</p> <table border="1" data-bbox="991 862 1887 935"> <tr> <td data-bbox="991 862 1087 935">3.c</td> <td data-bbox="1087 862 1793 935"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 862 1887 935">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 21 individuals (AMA, CBI, GEB, HDC, HLO, IH, JFA, JMB, JMC, JOI, LDM, MBR, MWS, NM, PGH, PPC, TAB, TO, VAC, WEO and ZDS) found that all individuals received restorative care.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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%	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	97%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planing, sealant, fluoride application, and oral hygiene instruction</i>	99%						
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	<b>Current findings on previous recommendation:</b>						

Section F: Specific Therapeutic and Rehabilitation Services

	<p>justified in a manner subject to clinical review.</p>	<p><b>Recommendation, March 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 (February-July 2010):</p> <table border="1" data-bbox="993 488 1887 748"> <tr> <td data-bbox="993 488 1087 748">4.</td> <td data-bbox="1087 488 1793 748"><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></td> <td data-bbox="1793 488 1887 748">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 22 individuals (AM, AW, DOM, FSG, GER, GGL, GW, JHM, JJS, JUS, LUJ, MEB, NCF, OAR, RBP, RHJ, RLL, RU, RUG, SRV, TB and TYB) found that all records were in compliance with this requirement.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</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>	100%
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>	100%			
F.9.c	<p>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>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 20% mean sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (February-July 2010):</p> <table border="1" data-bbox="993 414 1887 599"> <tr> <td data-bbox="993 414 1087 599">5.</td> <td data-bbox="1087 414 1793 599"><i>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.</i></td> <td data-bbox="1793 414 1887 599">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 22 individuals (AM, AW, DOM, FSG, GER, GGL, GW, JHM, JJS, JUS, LUJ, MEB, NCF, OAR, RBP, RHJ, RLL, RU, RUG, SRV, TB and TYB) found that all 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>	5.	<i>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.</i>	100%
5.	<i>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.</i>	100%			
F.9.d	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance</p>			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>based on a 100% sample of individuals scheduled for dental appointments during the review months (February-July 2010):</p> <table border="1" data-bbox="993 305 1892 342"> <tr> <td>6.a</td> <td><i>The individual attended the scheduled appointment</i></td> <td>56%</td> </tr> </table> <p>Comparative data indicated that the number of individuals who have not attended dental appointments increased from the past review period, when 72% of individuals attended their scheduled appointments. A review of MSH's dental data found that refusals, not staffing or transportation issues, continue to be the major reason for missed appointments. The facility provided the following data on missed appointments:</p> <table border="1" data-bbox="997 675 1820 1019"> <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>Feb</td> <td>88</td> <td>0</td> <td>1</td> </tr> <tr> <td>March</td> <td>73</td> <td>0</td> <td>2</td> </tr> <tr> <td>April</td> <td>76</td> <td>4</td> <td>0</td> </tr> <tr> <td>May</td> <td>92</td> <td>0</td> <td>0</td> </tr> <tr> <td>June</td> <td>83</td> <td>0</td> <td>5</td> </tr> <tr> <td>July</td> <td>77</td> <td>0</td> <td>3</td> </tr> </tbody> </table> <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>	6.a	<i>The individual attended the scheduled appointment</i>	56%	Month	Refused to come to appt	Unit staff procedural problem	Transportation problem	Feb	88	0	1	March	73	0	2	April	76	4	0	May	92	0	0	June	83	0	5	July	77	0	3
6.a	<i>The individual attended the scheduled appointment</i>	56%																															
Month	Refused to come to appt	Unit staff procedural problem	Transportation problem																														
Feb	88	0	1																														
March	73	0	2																														
April	76	4	0																														
May	92	0	0																														
June	83	0	5																														
July	77	0	3																														
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop	<b>Current findings on previous recommendations:</b>																															

Section F: Specific Therapeutic and Rehabilitation Services

	<p>strategies to overcome individuals' refusals to participate in dental appointments.</p>	<p><b>Recommendations 1 and 2, March 2010:</b></p> <ul style="list-style-type: none"> <li>• Continue strategies to ensure that WRPs addressing refusals are individualized.</li> <li>• Continue to monitor this requirement.</li> </ul> <p><b>Findings:</b> Using the DMH Dental Services Audit, MSH assessed its compliance based on a 27% mean sample of individuals scheduled for but refusing to attend dental appointments during the review months (February-July 2010):</p> <table border="1" data-bbox="991 597 1887 748"> <tr> <td data-bbox="991 597 1087 748">7.</td> <td data-bbox="1087 597 1793 748"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 597 1887 748">92%</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 MSH's data for F.9.d and F.9.e indicated that there was a significant discrepancy in the dental refusal data; a mean of 81 refusals and a mean of 14 respectively. Although the data for F.9.e represent the number of dental refusals that were sent to the WRPTs for interventions after the third refusal, neither the dentist nor the facility's data indicated that there were significantly fewer refusals than during the previous review period or that a significant number of individuals who initially refused did keep a subsequent appointment to validate the data. In addition, a review of 25 individuals from the list provided to the reviewer of individuals who refused dental appointments did not consistently represent those refusals addressed by the WRPTs (see findings below). Although the Dental Department has a database that accurately tracks appointments, refusals, and missed appointments, the facility does not have an adequate tracking system in place to ensure that</p>	7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	92%
7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments</i>	92%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>the WRPTs are consistently aware of dental refusals and implementing individualized WRPs addressing this area.</p> <p>The facility provided a draft of a protocol addressing non-adherence resulting from the initiation of a Quality Council project analyzing assessments regarding non-adherence. They found that the current assessments were too lengthy and did not provide adequate information about the reasons for non-adherence to guide the WRPTs. The facility will be exploring the use of a standardized tool to assess non-adherence issues. In September 2010, the Psychology Department will begin to assess, monitor, and track refusals. Individuals who have three refusals with hospital stays longer than 90 days will be assessed first unless other individuals with stays of less than 90 days are deemed a priority. The results of the assessments will be documented in the psychology progress notes and the WRPT will document the refusals in the Present Status section of the WRP with an associated open focus related to the reasons for the refusals.</p> <p>A review of records of 25 individuals (AC, BWT, CMM, DJP, DPR, DWN, ELC, FPR, GA, GAG, GMS, HMT, JAM, JMM, JOA, LAS, LMG, MC, MCF, MHC, NA, NAA, RJA, RJT and SCG) found that 17 WRPs did not include any mention of the refusals to attend the dental appointment and four had an open focus with interventions addressing refusals included in their WRPs; however, only one of the four WRPs was appropriately individualized.</p> <p><b>Compliance:</b> Partial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue efforts aimed at developing a facility-wide system addressing and tracking non-adherence issues.</li> <li>2. Continue strategies to ensure that WRPs addressing refusals are</li> </ol>
--	--	---

Section F: Specific Therapeutic and Rehabilitation Services

		individualized. 3. Continue to monitor this requirement.
--	--	---

Section G: Documentation

<b>G. Documentation</b>		
<b>G</b>	<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> MSH has maintained substantial compliance with the requirements of Section H of the Enhancement Plan and continues to decrease the use of seclusion and restraint.</p>
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, Standards Compliance Director</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. MSH's progress report and data</li> <li>2. MSH training rosters</li> <li>3. Medical records for the following 12 individuals: AP, EAO, GAA, JNN, JR, MC, MP, OC, RS, SAC, VMC and WDT</li> </ol>
H.1	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Since the last review, there have been no revisions to Special Order 119.06 and AD 3306. A review of episodes of restraint/seclusion found no incidents of prone restraint, containment or transportation.</p> <p>MSH continues to put significant efforts into decreasing the use of restraint and seclusion. The following comparison data demonstrates this:</p>

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

		<ul style="list-style-type: none"> <li>• The mean number of restraint episodes for the initial review conducted in 2006 was 161 as compared to 13 for the current review period</li> <li>• The mean number of seclusion episodes for the initial review conducted in 2006 was 7 as compared to 1.5 for the current review period</li> </ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>									
H.2	Each State hospital shall ensure that restraints and seclusion:	<p><b>Compliance:</b> Substantial.</p>									
H.2.a	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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 (a total of nine episodes) of initial seclusion orders each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 1154 1887 1382"> <tr> <td data-bbox="991 1154 1087 1195">1.</td> <td data-bbox="1087 1154 1793 1195"><i>Seclusion is used in a documented manner.</i></td> <td data-bbox="1793 1154 1887 1195">89%</td> </tr> <tr> <td data-bbox="991 1195 1087 1268">2.</td> <td data-bbox="1087 1195 1793 1268"><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 1195 1887 1268">100%</td> </tr> <tr> <td data-bbox="991 1268 1087 1382">3.</td> <td data-bbox="1087 1268 1793 1382"><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 1268 1887 1382">100%</td> </tr> </table>	1.	<i>Seclusion is used in a documented manner.</i>	89%	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>Seclusion is used in a documented manner.</i>	89%									
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%									

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

		<p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period for items 2 and 3; item 1 was 98% in the previous review period.</p> <p>A review of six episodes of seclusion for four individuals (GAA, JNN, MC and OC) 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 (a total of 77 episodes) of initial restraint orders each month during the review period (February-July 2010):</p> <table border="1" data-bbox="991 711 1892 935"> <tr> <td data-bbox="991 711 1087 748">1.</td> <td data-bbox="1087 711 1797 748"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1797 711 1892 748">99%</td> </tr> <tr> <td data-bbox="991 748 1087 824">2.</td> <td data-bbox="1087 748 1797 824"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1797 748 1892 824">99%</td> </tr> <tr> <td data-bbox="991 824 1087 935">3.</td> <td data-bbox="1087 824 1797 935"><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="1797 824 1892 935">99%</td> </tr> </table> <p>(For the current review period, 21% of the 77 restraint episodes involved one individual, who had 16 restraint events in February 2010.)</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 20 episodes of restraint for nine individuals (AP, EAO, JR, MP, OC, RS, SAC, VMC and WDT) 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>	1.	<i>Restraint is used in a documented manner.</i>	99%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	99%	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>Restraint is used in a documented manner.</i>	99%									
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	99%									
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%									

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

		<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, March 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 (February-July 2010):</p> <table border="1" data-bbox="993 675 1887 1198"> <tr> <td data-bbox="993 675 1087 748">4.</td> <td data-bbox="1087 675 1793 748"><i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1793 675 1887 748">100%</td> </tr> <tr> <td data-bbox="993 748 1087 972">5.</td> <td data-bbox="1087 748 1793 972"><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="1793 748 1887 972">100%</td> </tr> <tr> <td data-bbox="993 972 1087 1198">6.</td> <td data-bbox="1087 972 1793 1198"><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 data-bbox="1793 972 1887 1198">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 four individuals (GAA, JNN, MC and OC) found documentation in all WRPs addressing behaviors,</p>	4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%	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 justification as to why they were not used.</i>	100%
4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	100%									
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 justification as to why they were not used.</i>	100%									

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

		<p>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 (February-July 2010):</p> <table border="1" data-bbox="993 451 1890 974"> <tr> <td data-bbox="993 451 1087 527">4.</td> <td data-bbox="1087 451 1795 527"><i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i></td> <td data-bbox="1795 451 1890 527">100%</td> </tr> <tr> <td data-bbox="993 527 1087 748">5.</td> <td data-bbox="1087 527 1795 748"><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 data-bbox="1795 527 1890 748">99%</td> </tr> <tr> <td data-bbox="993 748 1087 974">6.</td> <td data-bbox="1087 748 1795 974"><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 data-bbox="1795 748 1890 974">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> <p>A review of 20 episodes of restraint for nine individuals (AP, EAO, JR, MP, OC, RS, SAC, VMC and WDT) 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>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%	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>	99%	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>	99%
4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	100%									
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>	99%									
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>	99%									

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

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, March 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, March 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 episodes of seclusion each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 971 1887 1045"> <tr> <td data-bbox="993 971 1087 1045">7.</td> <td data-bbox="1087 971 1793 1045"><i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 971 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. See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, MSH assessed its compliance based on a 100% mean sample of episodes of restraint each month during the review period (February-July 2010):</p> <table border="1" data-bbox="993 1382 1887 1416"> <tr> <td data-bbox="993 1382 1087 1416">7.</td> <td data-bbox="1087 1382 1793 1416"><i>Restraint is terminated as soon as the individual is no</i></td> <td data-bbox="1793 1382 1887 1416">99%</td> </tr> </table>	7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%	7.	<i>Restraint is terminated as soon as the individual is no</i>	99%
7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%						
7.	<i>Restraint is terminated as soon as the individual is no</i>	99%						

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

		<table border="1" data-bbox="993 191 1902 232"> <tr> <td data-bbox="993 191 1094 232"></td> <td data-bbox="1094 191 1797 232"><i>longer an imminent danger to self or others.</i></td> <td data-bbox="1797 191 1902 232"></td> </tr> </table> <p>Comparative data indicated that MSH maintained a compliance rate of at least 90% from the previous review period. See H.2.b for review findings.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>		<i>longer an imminent danger to self or others.</i>	
	<i>longer an imminent danger to self or others.</i>				
H.3	<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, March 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 (February-July 2010):</p> <table border="1" data-bbox="993 898 1902 1049"> <tr> <td data-bbox="993 898 1094 1049">8.</td> <td data-bbox="1094 898 1797 1049"><i>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 within one hour.</i></td> <td data-bbox="1797 898 1902 1049">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 six episodes of seclusion for four individuals (GAA, JNN, MC and OC) 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 assessed its compliance based on a 100% sample of initial restraint orders each month during the</p>	8.	<i>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 within one hour.</i>	100%
8.	<i>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 within one hour.</i>	100%			

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

		<p>review period (February-July 2010):</p> <table border="1" data-bbox="991 266 1890 415"> <tr> <td data-bbox="991 266 1087 415">8.</td> <td data-bbox="1087 266 1795 415"><i>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 restraint within one hour.</i></td> <td data-bbox="1795 266 1890 415">94%</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 20 episodes of restraint for nine individuals (AP, EAO, JR, MP, OC, RS, SAC, VMC and WDT) 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 for the months of February through July 2010 verified that out of a total of 187 staff due for annual training and 20 newly hired staff, all received and passed the Therapeutic Strategies and Interventions training.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	8.	<i>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 restraint within one hour.</i>	94%
8.	<i>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 restraint within one hour.</i>	94%			
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> In March 2010, MSH began documenting all seclusion and restraints</p>			

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

		<p>incidents using the WaRMSS Incident Management Module. In April 2010, all PRN and Stat medications were also entered in WaRMSS. 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> <p>In addition, Standards Compliance reviews the PRN/Stat WaRMSS database to ensure that the units have consistently and accurately entered this information into the database. 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, March 2010:</b> Continue to monitor this requirement.</p> <p><b>Findings:</b> There were no individuals placed in seclusion four or more times in 30 days during the review period.</p> <p>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 individuals who were in restraint more than three times in 30 days during the review period (February-July 2010):</p> <table border="1" data-bbox="991 302 1890 526"> <tr> <td data-bbox="991 302 1087 526">9.</td> <td data-bbox="1087 302 1793 526"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 302 1890 526">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 three individuals who were in restraint more than three times in 30 days during the review period (JR, MP and SAC) found that all WRPs included documentation within three business days.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue to monitor this requirement.</p>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	100%			
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, March 2010:</b> See F.1.b.</p>			

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

		<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, March 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.c	PRN medications are appropriately time limited.	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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, March 2010:</b> See F.3.a.iii.</p>

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

		<p><b>Findings:</b> See F.3.a.iii.</p> <p><b>Current recommendations:</b> See F.3.a.iii.</p>
H.6.e	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 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> <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, March 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 recommendations:</b> See F.3.h.i. and H.3</p>

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

H.8	Each State hospital shall:	<b>Compliance:</b> Not applicable.
H.8.a	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	There were no previous recommendations, as side rails are no longer used at MSH.
H.8.b	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><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> See H.8.a.</p> <p><b>Findings:</b> See H.8.a.</p> <p><b>Current recommendation:</b> None required.</p>

Section I: Protection from Harm

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 facility implemented procedures for the independent review of investigations before they are presented to the IRC. The independent reviewer, a member of the Standards Compliance staff, offered comments on 22 investigations. The system has improved the quality of the investigations and resulted in corrections to the Investigation Compliance Monitoring forms. The facility has agreed to continue this system until it is no longer necessary.</li> <li>2. The IRC minutes show the committee's attention to the quality and timeliness of investigation. The committee keeps a log of recommendations that includes the staff member responsible for implementation, the target date and status at follow-up.</li> <li>3. The facility has completed the conversion to WaRMSS. Staff were provided clear instructions on expectations and procedures for incorporating risk management elements into WRPs and were supported with training. These efforts resulted in the positive findings documented in this section of the report regarding the implementation of the Risk Management system. Specifically, review of a sample of WRPs found that high risk status of the individual was addressed in treatment objectives, incidents and triggers were cited in WRPs, and the recommendations from the Risk Management Committees were cited and implemented.</li> <li>4. The facility has continued to make improvements to the environment, making it safer for individuals. Examples include the renovation of bathrooms, the replacement of tall wardrobes, installation of collars around light strobes and the caulking of space between light fixtures and the wall.</li> <li>5. Program Managers have increased their on-unit presence and complete a 28-item checklist. In addition to reviewing environmental conditions, the checklist queries staffing issues related to assignments, position/ location on the unit, rounds, interactions with individuals and supervision</li> </ol>

Section I: Protection from Harm

		<p>provided by the Shift Lead.</p> <ol style="list-style-type: none"><li>6. The facility plans the move of the LPS individuals into the renovated building that formerly housed the children.</li><li>7. MSH has several projects underway to improve the quality of life at the facility, including the reduction of violence, the reduction of self-harm incidents in Program 2, increased training for nurses and Shift Leads, and enhancement of Program Review Committees in addressing incidents and triggers. Status reports on these and other project are reported regularly in the minutes of the Quality Council.</li></ol>
--	--	--

Section I: Protection from Harm

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. C. Fayloga, RN, Standards Compliance Risk Manager</li> <li>2. C. Loop, Supervising Special Investigator</li> <li>3. C. Lusch, Clinical Administrator</li> <li>4. K. Kolasinski, RN, Standards Compliance Risk Manager</li> <li>5. L. Dieckmann, PhD, Standards Compliance Psychologist</li> <li>6. M. Nunley, Director of Standards Compliance</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Twelve OSI investigations</li> <li>2. Selected IRC minutes and task tracking log</li> <li>3. Aggregate incident data</li> <li>4. Material related to the deaths of five individuals</li> <li>5. Training and other personnel information relevant to this section of the EP from HR for 18 staff members</li> <li>6. Clinical records of 12 individuals for most recent signing of rights notification</li> <li>7. 7 Headquarters Reportable Briefs</li> <li>8. OSI investigation log</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, March 2010:</b>            Research why HR did not report that the staff members who failed to report A/N in investigations #0570 and #0781 received counseling and remedy any problem uncovered.</p> <p><b>Findings:</b>            The facility responded that action was taken with each of the staff members in the cited investigations who failed to report A/N. Furthermore, the facility reports that the Assistant Clinical Administrator oversees a tracking system wherein HR sends a memo with all IRC recommendations to the program and each program maintains a folder with follow-up documentation.</p> <p>The facility reported that during the review period there were four instances in which staff failed to report as required by policy. Consequences ranged from informal counseling to a letter of instruction. The investigation of physical abuse made by CG, which determined that a staff member failed to report the incident by the close of shift, was one of the incidents cited by the facility and also was in this monitor's sample. The staff member received a letter of instruction.</p> <p>In response to these incidents, the IRC recommended to the Quality Council that focused training with relevant scenarios be provided to staff members who fail to report, rather than sending these staff back through standard training. Additionally, the recommendation was made to provide in-service training to managers to reinforce their role in ensuring that current policies regarding incident reporting are followed and to solicit from managers their thoughts on the causes of failure to report. Increased penalties for repeat offenders were also recommended.</p> <p><b>Current recommendation:</b>            Implement as planned the recommendations of the IRC addressing the failure of staff to report incidents.</p>
--	---------------------	---

Section I: Protection from Harm

I.1.a.ii	<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, March 2010:</b> Continue current practice and monitoring.</p> <p><b>Findings:</b> The DMH policies regarding Incident Management meet the requirements of this portion 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, March 2010:</b> Finalize SO 263 as planned.</p> <p><b>Findings:</b> SO 263 has been revised and is expected to be approved shortly.</p> <p><b>Other findings:</b> The investigations reviewed inconsistently documented whether a named staff member was removed from the unit. For example, the investigation of the 3/18/10 allegation of physical abuse makes no mention of removing the named staff member. Similarly, the investigation of the 3/25/10 allegation of verbal/psychological abuse and the investigations of the 1/13/10 and 2/15/10 allegations of physical abuse also make no mention of removing the named staff persons. The investigations of the 2/15/10 and 1/24/10 allegations of physical abuse, however, note that the staff members were removed. The named staff member was removed on 2/16/10 in the physical abuse allegation made by PZ and returned on 2/18/10, prior to the first OSI interview of alleged victim on 2/19/10.</p>

Section I: Protection from Harm

		<p>Procedures for removing staff members named in A/N/E allegations will be incorporated into SO 263, which the union is expected to have reviewed by mid-September and which is expected to be effective by October 1, 2010.</p> <p><b>Current recommendation:</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>																																		
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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Document relevant findings related to staff members' training records in investigation reports.</p> <p><b>Findings:</b> This issue did not arise in the investigations reviewed.</p> <p><b>Recommendation 2, March 2010:</b> Continue current practice of providing annual A/N/E training to staff members and monitoring attendance.</p> <p><b>Findings:</b></p> <table border="1" data-bbox="953 1079 1822 1422"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_L</td> <td>1/29/10</td> <td>1/4/10</td> <td>1/29/10</td> <td>2/9/10</td> </tr> <tr> <td>_K</td> <td>11/26/08</td> <td>10/27/08</td> <td>11/26/08</td> <td>8/14/10</td> </tr> <tr> <td>_S</td> <td>4/8/08</td> <td>2/15/08</td> <td>4/8/08</td> <td>7/14/10</td> </tr> <tr> <td>_G</td> <td>1/5/07</td> <td>11/21/06</td> <td>7/5/96</td> <td>4/14/10</td> </tr> <tr> <td>_A</td> <td>6/2/06</td> <td>5/31/06</td> <td>6/2/06</td> <td>7/13/10</td> </tr> </tbody> </table>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_L	1/29/10	1/4/10	1/29/10	2/9/10	_K	11/26/08	10/27/08	11/26/08	8/14/10	_S	4/8/08	2/15/08	4/8/08	7/14/10	_G	1/5/07	11/21/06	7/5/96	4/14/10	_A	6/2/06	5/31/06	6/2/06	7/13/10
Staff member*	Date of:																																			
	Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training																																
_L	1/29/10	1/4/10	1/29/10	2/9/10																																
_K	11/26/08	10/27/08	11/26/08	8/14/10																																
_S	4/8/08	2/15/08	4/8/08	7/14/10																																
_G	1/5/07	11/21/06	7/5/96	4/14/10																																
_A	6/2/06	5/31/06	6/2/06	7/13/10																																

Section I: Protection from Harm

		<table border="1"> <tr><td>_L</td><td>7/8/05</td><td>5/26/05</td><td>7/8/05</td><td>8/17/09</td></tr> <tr><td>_A</td><td>8/1/03</td><td>6/13/03</td><td>8/1/03</td><td>6/16/10</td></tr> <tr><td>_M</td><td>12/21/01</td><td>11/8/01</td><td>12/21/01</td><td>2/8/10</td></tr> <tr><td>_T</td><td>8/3/01</td><td>6/20/01</td><td>8/3/01</td><td>9/14/09</td></tr> <tr><td>_C</td><td>1/3/00</td><td>12/15/99</td><td>1/3/00</td><td>6/14/10</td></tr> <tr><td>_P</td><td>10/29/99</td><td>9/14/99</td><td>10/29/99</td><td>5/12/10</td></tr> <tr><td>_J</td><td>9/11/98</td><td>8/13/98</td><td>9/11/98</td><td>6/14/10</td></tr> <tr><td>_Z</td><td>6/29/98</td><td>6/22/98</td><td>6/26/98</td><td>7/15/10</td></tr> <tr><td>_J</td><td>10/22/90</td><td>7/2/90</td><td>5/3/90 &amp; 10/22/90</td><td>9/14/09</td></tr> <tr><td>_W</td><td>7/9/90</td><td>NA</td><td>7/9/90</td><td>4/14/10</td></tr> <tr><td>_S</td><td>4/21/87</td><td>NA</td><td>4/21/87 &amp; 2/8/07</td><td>6/14/10</td></tr> <tr><td>_L</td><td>11/2/81</td><td>NA</td><td>8/28/06</td><td>NA</td></tr> <tr><td>_B</td><td>10/22/81</td><td>3/17/10</td><td>8/13/07</td><td>6/8/09</td></tr> </table>	_L	7/8/05	5/26/05	7/8/05	8/17/09	_A	8/1/03	6/13/03	8/1/03	6/16/10	_M	12/21/01	11/8/01	12/21/01	2/8/10	_T	8/3/01	6/20/01	8/3/01	9/14/09	_C	1/3/00	12/15/99	1/3/00	6/14/10	_P	10/29/99	9/14/99	10/29/99	5/12/10	_J	9/11/98	8/13/98	9/11/98	6/14/10	_Z	6/29/98	6/22/98	6/26/98	7/15/10	_J	10/22/90	7/2/90	5/3/90 & 10/22/90	9/14/09	_W	7/9/90	NA	7/9/90	4/14/10	_S	4/21/87	NA	4/21/87 & 2/8/07	6/14/10	_L	11/2/81	NA	8/28/06	NA	_B	10/22/81	3/17/10	8/13/07	6/8/09	
_L	7/8/05	5/26/05	7/8/05	8/17/09																																																																
_A	8/1/03	6/13/03	8/1/03	6/16/10																																																																
_M	12/21/01	11/8/01	12/21/01	2/8/10																																																																
_T	8/3/01	6/20/01	8/3/01	9/14/09																																																																
_C	1/3/00	12/15/99	1/3/00	6/14/10																																																																
_P	10/29/99	9/14/99	10/29/99	5/12/10																																																																
_J	9/11/98	8/13/98	9/11/98	6/14/10																																																																
_Z	6/29/98	6/22/98	6/26/98	7/15/10																																																																
_J	10/22/90	7/2/90	5/3/90 & 10/22/90	9/14/09																																																																
_W	7/9/90	NA	7/9/90	4/14/10																																																																
_S	4/21/87	NA	4/21/87 & 2/8/07	6/14/10																																																																
_L	11/2/81	NA	8/28/06	NA																																																																
_B	10/22/81	3/17/10	8/13/07	6/8/09																																																																
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 statement that shall be kept with their personnel records evidencing their	<p>*Only last initials are provided to protect confidentiality.</p> <p>As shown above, only one of the 18 staff members sampled was substantively late in attending annual A/N/E training and the relevant training records of another staff member could not be located.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring for compliance with attendance at annual A/N/E training.</p> <p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Ensure that IRC recommendations for disciplinary action, counseling, and training are tracked through to resolution.</p> <p><b>Findings:</b> The IRC maintains a Tracking Log that in addition to information identifying</p>																																																																		

Section I: Protection from Harm

	<p>recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p>the investigation includes the area of deficiency, the plan of correction and the staff member responsible, the target date and, critically, follow-up information. For example, in the investigation of the psychological and physical abuse of JC (1/16/10), the IRC determined that the individual's triggers were not addressed in his WRP and that staff did not use recovery language when they described the individual's behavior to the investigator. The tracking log indicates that recovery training was provided for these staff and the individual's WRP was revised to include his triggers and how staff should respond to prevent escalation.</p> <p><b>Recommendation 1, March 2010:</b> Verify that HR is receiving notification of counseling.</p> <p><b>Findings:</b> During the investigation of the allegation of physical abuse made by CG on 2/15/10 (but not closed until 6/15/10), a staff member was found to have failed to report the abuse allegation before the end of shift. HR reports that this staff member will receive training on incident reporting when the staff member returns from vacation.</p> <p><b>Other findings:</b> As reported in the table in the cell above, 17 of the 18 staff members sampled had completed A/N/E training within the last year. Except for two employees hired in 1981, the remaining 16 employees sampled signed the Mandatory Reporter form on or before their date of hire.</p> <p><b>Current recommendation:</b> Continue to provide appropriate counseling and training to staff members who fail to report incidents 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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> A review of the records of 11 individuals found that 10 had been given the opportunity to sign the notification of rights within the past year. The remaining individual was "late" by only a few days.</p> <table border="1" data-bbox="961 488 1415 984"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>KS</td> <td>8/25/10</td> </tr> <tr> <td>KB</td> <td>8/12/10</td> </tr> <tr> <td>MM</td> <td>3/11/10 refused</td> </tr> <tr> <td>KG</td> <td>2/19/10</td> </tr> <tr> <td>GS</td> <td>12/17/09</td> </tr> <tr> <td>SA</td> <td>12/17/09</td> </tr> <tr> <td>AP</td> <td>12/14/09</td> </tr> <tr> <td>JK</td> <td>11/23/09</td> </tr> <tr> <td>TD</td> <td>11/16/09</td> </tr> <tr> <td>LO</td> <td>10/1/09 refused</td> </tr> <tr> <td>HC</td> <td>8/26/09</td> </tr> </tbody> </table> <p>Review of the records of four individuals on Unit 412 (AZ, JT, ML and MW) found that none of the four had signed the form acknowledging receipt of the Statement of Rights. Rather, they signed only the section of the form acknowledging receipt of the Rules and Regulations. Staff confirmed that individuals are not offered the opportunity to sign the Statement of Rights annually, only on admission.</p> <p><b>Current recommendation:</b> Clarify the obligation of WRPTs to offer individuals the opportunity to discuss and sign the Statement of Rights annually.</p>	Individual	Date of most recent signing	KS	8/25/10	KB	8/12/10	MM	3/11/10 refused	KG	2/19/10	GS	12/17/09	SA	12/17/09	AP	12/14/09	JK	11/23/09	TD	11/16/09	LO	10/1/09 refused	HC	8/26/09
Individual	Date of most recent signing																									
KS	8/25/10																									
KB	8/12/10																									
MM	3/11/10 refused																									
KG	2/19/10																									
GS	12/17/09																									
SA	12/17/09																									
AP	12/14/09																									
JK	11/23/09																									
TD	11/16/09																									
LO	10/1/09 refused																									
HC	8/26/09																									

Section I: Protection from Harm

<p>I.1.a. vii</p>	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> A Rights Poster was affixed to a common area wall on the units visited.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.a. viii</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue making appropriate referrals to law enforcement.</p> <p><b>Findings:</b> The A/N/E investigations reviewed did not require referral to law enforcement.</p> <p><b>Current recommendation:</b> Continue current practice of making appropriate referrals to law enforcement.</p>
<p>I.1.a.ix</p>	<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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> Retaliatory action or threat of such action did not figure in any of the investigations reviewed.</p>

Section I: Protection from Harm

	appropriate or timely manner.	<p><b>Current recommendation:</b> Continue current practice and maintain vigilance in identifying situations where retaliation may be likely.</p>
I.1.b	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><b>Compliance:</b> Partial, but showing improvement with the addition of an independent review.</p>
I.1.b.i	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 persons with mental disorders;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Complete the review of the death of DG and track to completion any recommendations from the internal and external reviews.</p> <p><b>Findings:</b> The investigation of the death of DG has been completed.</p> <p><b>Recommendation 2, March 2010:</b> Continue current practice of tracking MIRC recommendations.</p> <p><b>Findings:</b> A MIRC tracking log is maintained.</p> <p><b>Recommendation 3, March 2010:</b> Make efforts to convene MIRC meetings in a timely manner.</p> <p><b>Findings:</b> The review of the unexpected deaths of five individuals yielded variable findings related to meeting the timelines prescribed in SO 205.05.</p>

Section I: Protection from Harm

Individual and date of death	Initial MIRC Final MIRC	SI report	Medical death summary	Independent External Review (IER)
DG 1/29/10	2/11/10 4/12/10	7/9/10	2/8/10	2/28/10
CR 3/12/10	3/25/10	Not finalized per OSI log	3/25/10	Not included in death material
JT 3/14/10	3/25/10 4/5/10	Not finalized per OSI log	Not included in death material	4/14/10
IS 5/29/10	6/11/10	Not finalized per OSI log	Undated	7/30/10
NA 7/1/10	7/16/10	Not finalized per OSI log	7/15/10	Not included in death material

In the death materials provided, there are references in several cases to the SI report not being available because the SI was waiting for the autopsy or the toxicology report. The IER in several instances recommended that the SI complete a preliminary report that would include a statement that the report will be finalized when the autopsy is received. MIRC minutes state that the Medical Director and SI agree that a verbal presentation of the case at the meeting will suffice and the SI report will be reviewed when it is finalized.

This monitor does not have sufficient information to know whether an External Independent Review was requested in the deaths of NA and CR. Other materials in these two cases characterize them as "not expected."

Section I: Protection from Harm

		<p><b>Current recommendation:</b> Make efforts to meet the timelines for the completion of reviews in the SO.</p>
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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Ensure that investigations are conducted by personnel skilled in conducting investigations and writing investigation reports.</p> <p><b>Findings:</b> The work of the independent reviewer has improved the quality of investigations conducted by trained OSI investigators. In addition, DMH has provided teleconference training to OSI investigators in all of the facilities on the requirements of the EP.</p> <p><b>Recommendation 2, March 2010</b> Provide an objective review of investigation reports to ensure they meet EP standards before they are submitted to the IRC. This is one component of the Correction and Maintenance Plan summarized in the Summary of Progress introduction to this section of the report.</p> <p><b>Findings:</b> The facility maintained the practice of providing an independent review of A/N/E investigations during the review period. The independent reviewer reviewed 22 investigations and Monitoring Compliance forms. The independent review improved the investigations as evidenced by her work on the investigation of psychological/verbal abuse and neglect of MM (3/3/10). The individual provided the wrong name but a particularly distinct description of the staff member he was alleging abused him. The investigator simply determined there was no staff member by the name given on the unit. The independent reviewer recognized the inadequacy of this response and in consultation with other staff was able to identify the staff person. The investigator was instructed to interview this staff</p>

Section I: Protection from Harm

		<p>member as the subject of the allegation.</p> <p><b>Current recommendation:</b> Continue the practice of an independent review of A/N/E 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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The physical evidence that most commonly requires safeguarding is photos. One section of the investigation report of the physical abuse of MK states that the officer photographed injuries on MK's face and arm. Another section of the investigation report states that the officer observed the injuries but MK would not permit him to photograph them. Consequently, it is unclear whether photos were taken.</p> <p><b>Current recommendation:</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>
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, March 2010:</b> Evaluate the outcomes of the Incident Management Corrections/ Maintenance Plan after a period of implementation.</p> <p><b>Findings:</b> The facility is in agreement that the independent review of investigations will continue until all agree it is no longer necessary. The SC independent evaluator reviewed 22 investigations during the review period and made</p>

Section I: Protection from Harm

		<p>comments on each.</p> <p><b>Other findings:</b> See the cells below for findings related to the quality of the investigations reviewed.</p> <p><b>Current recommendation:</b> Continue to review the quality of investigations, both by the Supervising Special Investigator and the independent SC reviewer.</p>
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Conduct interviews as near to the report of the incident as possible in order to gather fresh information.</p> <p><b>Findings:</b> The sampled investigations yielded mixed findings related to timely interviews. In the investigation of the physical and psychological abuse of MM, which OSI received on 1/19/10, the first interviews were conducted on 1/19/10 with the alleged victim and two staff members. Similarly, the initial OSI interview of the alleged victim was conducted on the same day OSI received the allegation of physical abuse made by PZ. In contrast, in the investigation of the allegation of physical abuse of VA reported on 6/4/10 and completed by HPD, the alleged victim was not interviewed until 7/1/10.</p> <p><b>Recommendation 2, March 2010:</b> Provide an independent review of Compliance Monitoring Forms to ensure their accuracy.</p> <p><b>Findings:</b> The independent review of the investigations conducted by SC included review and comment on the accuracy of the Compliance Monitoring Forms as</p>

Section I: Protection from Harm

		<p>well as on the investigations themselves.</p> <p><b>Other findings:</b></p> <table border="1"> <thead> <tr> <th data-bbox="955 342 1297 415">Incident type</th> <th data-bbox="1297 342 1488 415">Date reported</th> <th data-bbox="1488 342 1682 415">Date to OSI</th> <th data-bbox="1682 342 1881 415">Date closed</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 415 1297 488">Allegation of abuse and neglect</td> <td data-bbox="1297 415 1488 488">11/27/09</td> <td data-bbox="1488 415 1682 488">1/27/10</td> <td data-bbox="1682 415 1881 488">7/9/10</td> </tr> <tr> <td data-bbox="955 488 1297 561">Allegation of physical and psychological abuse</td> <td data-bbox="1297 488 1488 561">1/13/10</td> <td data-bbox="1488 488 1682 561">1/19/10</td> <td data-bbox="1682 488 1881 561">5/19/10</td> </tr> <tr> <td data-bbox="955 561 1297 634">Allegation of physical and psychological abuse</td> <td data-bbox="1297 561 1488 634">1/16/10</td> <td data-bbox="1488 561 1682 634">1/28/10</td> <td data-bbox="1682 561 1881 634">3/8/10</td> </tr> <tr> <td data-bbox="955 634 1297 708">Allegation of physical abuse</td> <td data-bbox="1297 634 1488 708">1/24/10</td> <td data-bbox="1488 634 1682 708">1/26/10</td> <td data-bbox="1682 634 1881 708">2/2/10</td> </tr> <tr> <td data-bbox="955 708 1297 748">Allegation of abuse</td> <td data-bbox="1297 708 1488 748">1/25/10</td> <td data-bbox="1488 708 1682 748">1/28/10</td> <td data-bbox="1682 708 1881 748">2/10/10</td> </tr> <tr> <td data-bbox="955 748 1297 789">Death</td> <td data-bbox="1297 748 1488 789">1/29/10</td> <td data-bbox="1488 748 1682 789">1/29/10</td> <td data-bbox="1682 748 1881 789">7/9/10</td> </tr> <tr> <td data-bbox="955 789 1297 829">Allegation of neglect</td> <td data-bbox="1297 789 1488 829">2/9/10</td> <td data-bbox="1488 789 1682 829">2/12/10</td> <td data-bbox="1682 789 1881 829">2/23/10</td> </tr> <tr> <td data-bbox="955 829 1297 902">Allegation of physical abuse</td> <td data-bbox="1297 829 1488 902">2/15/10</td> <td data-bbox="1488 829 1682 902">2/16/10</td> <td data-bbox="1682 829 1881 902">3/30/10 &amp; 5/18/10</td> </tr> <tr> <td data-bbox="955 902 1297 976">Allegation of physical abuse</td> <td data-bbox="1297 902 1488 976">2/15/10</td> <td data-bbox="1488 902 1682 976">2/16/10</td> <td data-bbox="1682 902 1881 976">6/25/10</td> </tr> <tr> <td data-bbox="955 976 1297 1049">Allegation of physical abuse</td> <td data-bbox="1297 976 1488 1049">2/22/10</td> <td data-bbox="1488 976 1682 1049">Completed by HPD</td> <td data-bbox="1682 976 1881 1049">7/19/10</td> </tr> <tr> <td data-bbox="955 1049 1297 1122">Allegation of psychological abuse/verbal/neglect</td> <td data-bbox="1297 1049 1488 1122">3/4/10</td> <td data-bbox="1488 1049 1682 1122">3/24/10</td> <td data-bbox="1682 1049 1881 1122">6/5/10</td> </tr> <tr> <td data-bbox="955 1122 1297 1195">Allegation of physical abuse</td> <td data-bbox="1297 1122 1488 1195">3/18/10</td> <td data-bbox="1488 1122 1682 1195">3/22/10</td> <td data-bbox="1682 1122 1881 1195">5/22/10</td> </tr> <tr> <td data-bbox="955 1195 1297 1268">Allegation of psychological abuse</td> <td data-bbox="1297 1195 1488 1268">On or before 4/9</td> <td data-bbox="1488 1195 1682 1268">9/15/09</td> <td data-bbox="1682 1195 1881 1268">6/28/10</td> </tr> </tbody> </table> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li data-bbox="955 1365 1881 1393">1. Continue current practice of HPD timely response to allegations of</li> </ol>	Incident type	Date reported	Date to OSI	Date closed	Allegation of abuse and neglect	11/27/09	1/27/10	7/9/10	Allegation of physical and psychological abuse	1/13/10	1/19/10	5/19/10	Allegation of physical and psychological abuse	1/16/10	1/28/10	3/8/10	Allegation of physical abuse	1/24/10	1/26/10	2/2/10	Allegation of abuse	1/25/10	1/28/10	2/10/10	Death	1/29/10	1/29/10	7/9/10	Allegation of neglect	2/9/10	2/12/10	2/23/10	Allegation of physical abuse	2/15/10	2/16/10	3/30/10 & 5/18/10	Allegation of physical abuse	2/15/10	2/16/10	6/25/10	Allegation of physical abuse	2/22/10	Completed by HPD	7/19/10	Allegation of psychological abuse/verbal/neglect	3/4/10	3/24/10	6/5/10	Allegation of physical abuse	3/18/10	3/22/10	5/22/10	Allegation of psychological abuse	On or before 4/9	9/15/09	6/28/10
Incident type	Date reported	Date to OSI	Date closed																																																							
Allegation of abuse and neglect	11/27/09	1/27/10	7/9/10																																																							
Allegation of physical and psychological abuse	1/13/10	1/19/10	5/19/10																																																							
Allegation of physical and psychological abuse	1/16/10	1/28/10	3/8/10																																																							
Allegation of physical abuse	1/24/10	1/26/10	2/2/10																																																							
Allegation of abuse	1/25/10	1/28/10	2/10/10																																																							
Death	1/29/10	1/29/10	7/9/10																																																							
Allegation of neglect	2/9/10	2/12/10	2/23/10																																																							
Allegation of physical abuse	2/15/10	2/16/10	3/30/10 & 5/18/10																																																							
Allegation of physical abuse	2/15/10	2/16/10	6/25/10																																																							
Allegation of physical abuse	2/22/10	Completed by HPD	7/19/10																																																							
Allegation of psychological abuse/verbal/neglect	3/4/10	3/24/10	6/5/10																																																							
Allegation of physical abuse	3/18/10	3/22/10	5/22/10																																																							
Allegation of psychological abuse	On or before 4/9	9/15/09	6/28/10																																																							

Section I: Protection from Harm

		<p>A/N/E.</p> <p>2. Conduct interviews as near to the report of the incident as possible.</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, March 2010:</b> See earlier recommendations related to timely interviews and the accuracy of Investigation Compliance Monitoring Forms.</p> <p><b>Findings:</b> Please see table in the cell above which shows that four of the 12 sampled A/N investigations were completed within 30 business days.</p> <p><b>Other findings:</b> The OSI investigations log shows 36 investigations not identified as closed that have exceeded the 30 business day timeframe established by the EP. The facility reported that 67% of the 33 investigations due to be closed during the review period met the EP timeline, with a range of 0% in May and June to 100% in July. [May, June, July total of investigations due to be closed was four.]</p> <p><b>Current recommendation:</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>
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</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Critically review investigations to ensure that rationales for determinations are provided.</p>

	<p>separately:</p>	<p><b>Findings:</b>  The investigation of the allegation of sexual abuse of CA failed to provide a logical and convincing rationale for the determination that the allegation was unsubstantiated. Specifically, the investigation failed to account for the inability to determine the date on which the incident occurred. The victim was unsure of the date, citing January 11, 18 or 19. Some documentation states the incident occurred on January 25 and the HPD reports the incident as occurring on January 26. Despite the uncertainty of the date of the incident, the named staff member was determined not to have engaged in the alleged behavior because she “was not on the unit at the time of the incident.” She was conducting a class on the morning of January 25. This case was not reviewed by the SC independent investigator.</p> <p><b>Recommendation 2, March 2010:</b>  Ensure that OSI investigations use the preponderance of evidence standard and the SIR definitions, not penal code.</p> <p><b>Findings:</b>  None of the investigations of A/N/E reviewed used penal code definitions.</p> <p><b>Other findings:</b>  Recommendations made in the investigation of the allegation of physical abuse made by CG on 2/15/10 did not evidence careful review by the OSI. The investigator recommended that the team open a focus for false allegations in the individual's WRP. The OSI supervisor's review occurred on 7/23/10, five months after the individual had been discharged—a fact mentioned in the report. This issue was identified also by the independent reviewer.</p> <p><b>Current recommendation:</b>  Critically review investigations to ensure that rationales for determinations are provided and build upon the incident definitions in Special Order 263.</p>
--	--------------------	--

Section I: Protection from Harm

<p>I.1.b. iv.3(i)</p>	<p>each allegation of wrongdoing investigated;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice of identifying staff misconduct embedded in another allegation in the investigation reports and in the IRC review of the incident. Continue to make recommendations for appropriate counseling/discipline.</p> <p><b>Findings:</b> The investigation of the allegation of physical and psychological abuse of MM (1/13/10) also included an allegation of Inappropriate Staff-Patient Relationship, a violation of AD 2109, yet the investigation made no inquiry into and no findings related to the inappropriate relationship allegation.</p> <p><b>Current recommendation:</b> Ensure that investigations address all allegations made or coded in the reporting of an incident.</p>
<p>I.1.b. iv.3(ii)</p>	<p>the name(s) of all witnesses;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Review all investigation reports to ensure they meet the EP standards. Return those that are deficient to the investigator for further work or take other appropriate action that results in a complete and accurate investigation.</p> <p><b>Findings:</b> Both the independent reviewer and the IRC have identified problems in investigations, have communicated their findings to OSI, and the office has responded with corrections that include additional interviews and addendums to the reports.</p>

Section I: Protection from Harm

		<p><b>Other findings:</b> The names of all persons identified as witness are provided in the investigation report.</p> <p><b>Current recommendation:</b> Continue current efforts to identify all possible witnesses to an incident.</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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> All investigations reviewed included the names of alleged perpetrators and victims.</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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Ensure that investigations meet EP standards.</p> <p><b>Findings:</b> See various cells in this section of the report.</p> <p><b>Recommendation 2, March 2010:</b> Avoid practices, such as failure to conduct critical interviews, which call the incident management process into question.</p> <p><b>Findings:</b> There were problematic interviews in two of the investigations reviewed:</p>

Section I: Protection from Harm

		<ul style="list-style-type: none"> <li>• In the investigation of the allegation of physical abuse of MK, a staff member at 7:00 AM drew up a syringe of medication that was to be administered at 1:00 PM. The investigator did not question this staff member about why he/she drew up the syringe six hours early.</li> <li>• In the investigation of psychological/verbal abuse and neglect of MM, he alleged that he was forced to take off all his clothes and lie on a bed during the admission process to a new unit and that during that process he was ridiculed. During the investigation, the investigator asked the named staff member if he made MM lie on the floor with no clothes on—an allegation that was not made by MM or anyone else. The named staff member denied making MM lie on the floor unclothed. The independent investigator made several suggestions and raised several questions about this investigation.</li> </ul> <p>The IRC noted that in the investigation of physical abuse of KL (not in the review sample), the investigator did not interview the alleged victim and questioned why. The committee recommended that the investigation be returned to OSI for an addendum to be written explaining that the individual had been discharged and so the conclusion was based on a compilation of other interviews.</p> <p><b>Current recommendation:</b> Provide a careful review of investigations by the Supervising Special Investigator, the independent reviewer, and the IRC.</p>
I.1.b. iv.3(v)	a summary of each interview;	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue current standard practice of providing the names and titles of all persons interviewed, the date of the interview and a summary of the content of the interview.</p>

Section I: Protection from Harm

		<p><b>Findings:</b> All investigations reviewed documented the information cited above.</p> <p><b>Recommendation 2, March 2010:</b> Complete essential interviews in a timely manner to protect the integrity of the investigation.</p> <p><b>Findings:</b> See I.1.b.iv.1 and I.b.iv.3(iv).</p> <p><b>Other findings:</b> In the investigation of the allegation of physical abuse of MK on 3/18/10, the investigator conducted a second interview of a witness to clarify the circumstances under which the injection in question was given. This is viewed as a positive action on the part of the investigator.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
I.1.b. iv.3(vi)	a list of all documents reviewed during the investigation;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Identify relevant portions of the documents reviewed and their role in the investigation.</p> <p><b>Findings:</b> In the investigation of the allegation of physical abuse made by MK on 3/18/10, the investigator checked and reported findings from several documents that were germane to the investigation. These include the physician's order that required staff to secure a blood sample and the TSI training records of six staff. He further checked with the social worker to ensure that the Public Guardian (the individual's conservator) consented to the securing of the blood sample over the individual's objection.</p>

Section I: Protection from Harm

		<p>All of the investigations reviewed contained a list of documents reviewed.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> In most of the investigations reviewed, the named staff member's history of involvement as the subject in allegations of A/N/E was reviewed as was the individual's history of making allegations. In others, however, as in the investigation of the alleged physical abuse of PZ (2/15/10), the review was limited to <i>sustained</i> cases involving the named staff member.</p> <p><b>Current recommendation:</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>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 recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue current practice while awaiting DMH search policy.</p> <p><b>Findings:</b> DMH has not yet finalized the search policy. During the review period, the facility has not conducted any searches like the one that raised the question and need for a clear policy.</p>

Section I: Protection from Harm

		<p><b>Recommendation 2, March 2010:</b> Ensure that rationales for determinations address the essential elements of the incident type under investigation.</p> <p><b>Findings:</b> Several investigations reviewed did not provide a clear and convincing rationale for the determinations. Please see the cell below and I.1.b.iv.3.</p> <p><b>Other findings:</b> Several investigations reviewed by the IRC cite a staff member's violation of facility policy, e.g., medication administration policy, computer password security, outside food purchases, locking dayroom doors.</p> <p><b>Current recommendation:</b> Continue to identify breaches of policy in investigations.</p>
<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, March 2010:</b> Provide strong supervisory review of investigations as envisioned in the Incident Management Corrections/Maintenance Plan.</p> <p><b>Findings:</b> As noted previously, the facility has continued to provide an independent review by Standards Compliance staff of the OSI investigations and Investigation Compliance Monitoring forms.</p> <p><b>Other findings:</b> See I.1.b.iv.3 for the recounting of an investigation that failed to support the investigator's conclusion.</p> <p>In the investigation of the physical abuse of MK (1/24/10), MK told investigators the incident occurred on Friday, January 19, but January 19</p>

Section I: Protection from Harm

		<p>was a Tuesday. MK told HPD that the incident occurred on January 23. The IDN states the incident occurred on January 24, as per the Patients' Rights Advocate's report. The investigator unfounded the case stating that neither of the two named staff members were on the unit on the day of the incident--without dealing with the problem of the several dates cited.</p> <p><b>Current recommendation:</b> Ensure a strong supervisory review of the conclusions drawn in investigations.</p>
<p>I.1.b. iv.4</p>	<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, March 2010:</b> Address the lax supervision of investigations by implementation of the plan described in the Summary of Progress.</p> <p><b>Findings:</b> The facility implemented, as agreed, a process for the independent review of investigations. Data supports that 22 investigations were reviewed by SC with comments sent to OSI and a response returned from OSI with corrections made or a rationale provided for not heeding the findings of the independent reviewer. This exchange improved the quality of the investigations.</p> <p><b>Current recommendation:</b> Continue the independent review of investigations until the capacity to critically critique and improve investigations is developed within OSI.</p>
<p>I.1.c</p>	<p>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</p>	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue current IRC practice of tracking recommendations.</p>

Section I: Protection from Harm

	<p>such actions and the corresponding outcomes.</p>	<p><b>Findings:</b> As reported, the IRC maintains a color-coded tracking log that identifies recommendations for corrective actions, the staff member responsible and target date, and follow-up (status of implementation).</p> <p><b>Recommendation 2, March 2010:</b> Determine if there is a problem in HR not receiving documentation of counseling or not taking action regarding discipline when these have been recommended in investigations and by the IRC. Take appropriate action to remedy the problem.</p> <p><b>Findings:</b> The facility reported that it has implemented a system whereby HR sends a memo with all recommendations to the program and each program maintains a folder with follow-up documentation. The Assistant Clinical Administrator oversees this process. As reported, corrective action was taken in the incident alleging the abuse of CG (2/15/10) when a staff member failed to report by the close of shift.</p> <p>The IRC Tracking Log follows discipline/counseling/training recommendations through to completion.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>
<p>I.1.d</p>	<p>Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:</p>	<p><b>Compliance:</b> Substantial.</p>

Section I: Protection from Harm

I.1.d.i	type of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue the facility's focus on increasing the safety of individuals in care.</p> <p><b>Findings:</b> The facility provided bar graph data comparing the number of A/N/E allegations during the current and prior reporting period as shown in the table below. Review of the OSI Investigation log finds 13 investigations of alleged sexual abuse during the review period. Three individuals (SM, CT and CH) each reported more than one sexual abuse allegation: SM reported three and the two other individuals each reported two.</p> <table border="1" data-bbox="961 672 1713 1052"> <thead> <tr> <th>Abuse type</th> <th>Aug 2009- Jan 2010</th> <th>Feb 2010- July 2010</th> </tr> </thead> <tbody> <tr> <td>Physical</td> <td>28</td> <td>36</td> </tr> <tr> <td>Verbal</td> <td>6</td> <td>10</td> </tr> <tr> <td>Psychological</td> <td>6</td> <td>4</td> </tr> <tr> <td>Sexual</td> <td>4</td> <td>18</td> </tr> <tr> <td>Neglect</td> <td>12</td> <td>15</td> </tr> <tr> <td>Exploitation</td> <td>NA</td> <td>5</td> </tr> <tr> <td>Rights Violations</td> <td>4</td> <td>4</td> </tr> <tr> <td>Total</td> <td>60</td> <td>92</td> </tr> </tbody> </table> <p>MSH's data for incidents involving physical or sexual aggression (not related to abuse allegations) show a decrease in frequency in the current review period as compared with the preceding one in three of the six incident types:</p> <table border="1" data-bbox="961 1279 1873 1383"> <thead> <tr> <th>Incident type</th> <th>8/1/09-1/31/10</th> <th>2/1-7/31/10</th> </tr> </thead> <tbody> <tr> <td>Peer aggression-physical</td> <td>580</td> <td>632</td> </tr> <tr> <td>Peer aggression-verbal</td> <td>115</td> <td>72</td> </tr> </tbody> </table>	Abuse type	Aug 2009- Jan 2010	Feb 2010- July 2010	Physical	28	36	Verbal	6	10	Psychological	6	4	Sexual	4	18	Neglect	12	15	Exploitation	NA	5	Rights Violations	4	4	Total	60	92	Incident type	8/1/09-1/31/10	2/1-7/31/10	Peer aggression-physical	580	632	Peer aggression-verbal	115	72
Abuse type	Aug 2009- Jan 2010	Feb 2010- July 2010																																				
Physical	28	36																																				
Verbal	6	10																																				
Psychological	6	4																																				
Sexual	4	18																																				
Neglect	12	15																																				
Exploitation	NA	5																																				
Rights Violations	4	4																																				
Total	60	92																																				
Incident type	8/1/09-1/31/10	2/1-7/31/10																																				
Peer aggression-physical	580	632																																				
Peer aggression-verbal	115	72																																				

Section I: Protection from Harm

		<table border="1"> <tr> <td>Aggressive act to self</td> <td>318</td> <td>378</td> </tr> <tr> <td>Aggressive act to staff-physical</td> <td>305</td> <td>322</td> </tr> <tr> <td>Sexual assault</td> <td>12</td> <td>7</td> </tr> <tr> <td>Aggressive act to staff-verbal</td> <td>152</td> <td>107</td> </tr> <tr> <td>Total</td> <td>1482</td> <td>1518</td> </tr> </table> <p><b>Current recommendation:</b> Continue the facility's focus on increasing the safety of individuals in care.</p>	Aggressive act to self	318	378	Aggressive act to staff-physical	305	322	Sexual assault	12	7	Aggressive act to staff-verbal	152	107	Total	1482	1518
Aggressive act to self	318	378															
Aggressive act to staff-physical	305	322															
Sexual assault	12	7															
Aggressive act to staff-verbal	152	107															
Total	1482	1518															
I.1.d.ii	staff involved and staff present;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Identify staff members whose names appear more frequently as the alleged perpetrator in allegations of A/N/E. Look behind to identify the cause, if possible.</p> <p><b>Findings:</b> The facility has partially implemented this recommendation. Investigations document a review of A/N/E incidents in which a staff member named in the current investigation has been named in prior cases.</p> <p><b>Current recommendation:</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 the determination; however, do not limit the listing to sustained cases.</p>															
I.1.d.iii	individuals directly and indirectly involved;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> The facility provided the IRC and OSI logs, which identify by name the</p>															

Section I: Protection from Harm

		<p>individuals who reported allegations of A/N/E. As noted, each investigation documents the allegations made by the individual. The Risk Management system identifies individuals who have been the victim of two or more incidents of physical or sexual aggression or exploitation in the previous six months and requires that the individual's WRP address this vulnerability.</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, March 2010:</b> Continue current practice of tracking incident and aggression data to enable the facility to identify areas most in need of assistance.</p> <p><b>Findings:</b> The facility's data shows that during the period February-July 2010, the location identified most frequently in incident reports was the hallways, with approximately 63 incidents; followed by "other area" with approximately 54 incidents; and bedrooms with 41. The fewest number of incidents, two, occurred in the dining rooms.</p> <p>MSH data for the review period finds that Units 410, 412 and 416 were the location of the greatest number of incidents, with 474, 407 and 311 incidents respectively.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
I.1.d.v	date and time of incident;	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p>

Section I: Protection from Harm

		<p><b>Findings:</b>  Review of the MSH data on time of day of incidents for the current and previous review periods indicates that the number of incidents is increasing. Specifically, with few exceptions more incidents occurred during each one-hour period of the day in the current review period than in the preceding period. In the current review period, 150 or more incidents were recorded each hour from 3:00PM to 7:00 PM. In the preceding review period, no single hour interval saw 150 or more incidents.</p> <p>In the current review period, MSH incident totals for each month show that in the period February-May, monthly totals remained very stable ranging from 390-399.</p> <p>Aggregation of MSH data yields the findings below showing Saturday as having the fewest incidents and Wednesday the most:</p> <table border="1" data-bbox="955 820 1455 1201"> <tr> <td colspan="2">Total number of incidents per day of the week reported from 2/1/10 through 7/31/10</td> </tr> <tr> <td>Sunday</td> <td>284</td> </tr> <tr> <td>Monday</td> <td>353</td> </tr> <tr> <td>Tuesday</td> <td>352</td> </tr> <tr> <td>Wednesday</td> <td>383</td> </tr> <tr> <td>Thursday</td> <td>310</td> </tr> <tr> <td>Friday</td> <td>345</td> </tr> <tr> <td>Saturday</td> <td>267</td> </tr> </table> <p><b>Current recommendation:</b>  Continue current practice.</p>	Total number of incidents per day of the week reported from 2/1/10 through 7/31/10		Sunday	284	Monday	353	Tuesday	352	Wednesday	383	Thursday	310	Friday	345	Saturday	267
Total number of incidents per day of the week reported from 2/1/10 through 7/31/10																		
Sunday	284																	
Monday	353																	
Tuesday	352																	
Wednesday	383																	
Thursday	310																	
Friday	345																	
Saturday	267																	
I.1.d.vi	cause(s) of incident; and	<b>Current findings on previous recommendation:</b>																

		<p><b>Recommendation, March 2010:</b> Expand efforts to complete HQ briefs in a timely manner.</p> <p><b>Findings:</b> Review of seven HQ briefs identified as final briefs yielded largely positive findings identifying the facility's response. These include:</p> <ul style="list-style-type: none"> <li>• In response to the incident wherein an individual alleged that a staff member gave some money for the purchase of pizza (2/1/10), staff were provided training on boundaries.</li> <li>• In response to the unfounded allegation of sexual assault made by KO on 3/8/10, the facility reiterated the expectation that Mall staff assigned to bathroom areas remain vigilant, observing who goes in and out.</li> <li>• Counseling and the development of a Behavior Guideline were identified as the response to the suicide gesture made by TG on 3/22/10.</li> <li>• Transfer to a secure facility was under consideration following YH's attack on a staff member.</li> <li>• Following RL's attack on a peer, staff were alerted to the possibility that he had been cheeking meds and asked to observe him carefully at medication administration times. The WRPT was to consider the need for a Behavior Guideline.</li> </ul> <p>In contrast, the HQ brief related to the 2/3/10 incident involving PZ showed the incident coded as abuse. However, the narrative of the event describes PZ's refusal to follow rules regarding dorm access during Mall times and his threats against staff. There is no mention of his allegation of abuse.</p> <p><b>Current recommendation:</b> Ensure the narrative description of an incident matches the incident type code.</p>
--	--	--

Section I: Protection from Harm

<p>I.1.d. vii</p>	<p>outcome of investigation.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Ensure that the OSI log is corrected when a determination is overturned by the IRC if the log will be used as the source for outcome data.</p> <p><b>Findings:</b> These circumstances did not arise in any of the investigations sampled during the review period.</p> <p><b>Other findings:</b> The OSI investigation log shows that 33 investigations closed during the review period were determined to be not sustained or unfounded while two were determined sustained. Policy violations were identified in several of the investigations determined not sustained or unfounded.</p> <p><b>Current recommendation:</b> Keep the OSI log updated to reflect correctly determinations.</p>
<p>I.1.e</p>	<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</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As shown in the table in I.1.a.iv, all of the staff members sampled had cleared the criminal background check by their date of hire with the exception of four staff, all of whom were hired 20 years ago or more. One of these staff cleared the check in 2010. There is no record of a check for the other three.</p> <p><b>Compliance:</b> Substantial.</p>

Section I: Protection from Harm

	investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.	<b>Current recommendation:</b> Continue current practice.
--	---	--

Section I: Protection from Harm

2. Performance Improvement		
I.2	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><b>Methodology:</b></p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> <li>1. C. Fayloga, RN, Standards Compliance Risk Manager</li> <li>2. C. Lusch, Clinical Administrator</li> <li>3. K. Kolasinski, RN, Standards Compliance Risk Manager</li> <li>4. L. Dieckmann, PhD, Standards Compliance Psychologist</li> <li>5. M. Nunley, Director of Standards Compliance</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. WRPs of nine individuals for responses to RM committee recommendations</li> <li>2. WRPs of nine individuals for responses to triggers</li> <li>3. OSI investigation log</li> <li>4. WRPs of 16 individuals for reference to high risk status</li> <li>5. Quality Council minutes</li> <li>6. Monthly Key Indicator Report</li> </ol> <p><u>Observed:</u> MRMC</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:	<p><b>Compliance:</b> Substantial.</p>
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, March 2010:</b> Continue current practice of identifying individuals at risk for various conditions and identifying these risks in the individual's WRP.</p>

Section I: Protection from Harm

		<p><b>Findings:</b> The facility has transitioned to using the WaRMSS Risk Management module. The review of the WRPs of 16 individuals identified as in high risk groups revealed positive findings as indicated in I.2.b.v.</p> <p><b>Other findings:</b> The facility presented the following data:</p> <table border="1" data-bbox="953 485 1841 977"> <thead> <tr> <th></th> <th>Aug 2009-Jan 2010</th> <th>Feb-July 2010</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>55</td> <td>35</td> </tr> <tr> <td>Aggression to self resulting in major injury</td> <td>76</td> <td>57</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>19</td> <td>17</td> </tr> <tr> <td>Individuals with two or more aggressive acts in 7 days</td> <td>139</td> <td>133</td> </tr> <tr> <td>Individuals with four or more aggressive acts in 30 days</td> <td>83</td> <td>87</td> </tr> <tr> <td>Homicide threats</td> <td>0</td> <td>0</td> </tr> </tbody> </table> <p>The incidence of behavioral triggers related to peer aggression and aggression to self in the current review period as compared with the previous one shows a decrease in five of the six triggers.</p> <p><b>Current recommendation:</b> Continue current focus on the reduction of aggression.</p>		Aug 2009-Jan 2010	Feb-July 2010	Peer-to-peer aggression resulting in major injury	55	35	Aggression to self resulting in major injury	76	57	Aggression to staff resulting in major injury	19	17	Individuals with two or more aggressive acts in 7 days	139	133	Individuals with four or more aggressive acts in 30 days	83	87	Homicide threats	0	0
	Aug 2009-Jan 2010	Feb-July 2010																					
Peer-to-peer aggression resulting in major injury	55	35																					
Aggression to self resulting in major injury	76	57																					
Aggression to staff resulting in major injury	19	17																					
Individuals with two or more aggressive acts in 7 days	139	133																					
Individuals with four or more aggressive acts in 30 days	83	87																					
Homicide threats	0	0																					
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p>																					

Section I: Protection from Harm

		<p><b>Findings:</b> The facility is identifying individuals who meet triggers and thresholds as is reported in this section of the report.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
<p>I.2.a. iii</p>	<p>identification of systemic trends and patterns of high risk situations.</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice of identifying problem areas that require research and recommendations for remedies.</p> <p><b>Findings:</b> Recognizing the importance of the Program Review Committees as an early forum for addressing the treatment needs of individuals involved in incidents and those who have reached triggers and their pivotal role in keeping the Risk Management system functioning within the resources (time of highly qualified staff) available in the facility, MSH freed Quality Council members to attend these meetings, evaluate their functioning, and report to the QC their findings and those characteristics of the best-performing committees.</p> <p>QC minutes regularly record an update from the Aggression Reduction Committee. Clearly defining the roles and responsibilities of unit staff and hospital police when they are called to a unit because of an incident was noted as an issue in all of the facilities. Reportedly, staff stepping back and relying on HPD to handle the incident is a common problem in all of the facilities.</p> <p>MSH is addressing attention to reducing self-injury in Program II. The June 2010 minutes note that honor credits have more impact than By Choice</p>

Section I: Protection from Harm

		<p>on the behavior of these individuals because they increase positive interactions between staff and individuals. The facility will continue to gather data on the impact of interventions.</p> <p>See also I.2.c.</p> <p><b>Current recommendation:</b> Continue current practice of identify high risk situations, implementing strategies to reduce the inherent risks and monitoring their efficacy.</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> Substantial.</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, March 2010:</b> Continue current practice, including monitoring for implementation of (or rationale for not implementing) recommendations made by Risk Management committees.</p> <p><b>Findings:</b> See I.2.b.v for the positive findings related to WRPs addressing recommendations made by Risk Management Committees.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring during the maintenance phase.</p>
I.2.b.ii	<p>timely corrective actions by teams and/or disciplines to address systemic trends and patterns;</p>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Take measures to ensure that WRPTs address the recommendations made</p>

Section I: Protection from Harm

		<p>by the ETRC when they next meet.</p> <p><b>Findings:</b> See table in I.2.b.v, which provides positive findings from the review of 22 recommendations made on behalf of nine individuals by ETRC, MRMC and FRC.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring during the maintenance phase.</p>
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> As is clear from the positive findings reported in I.2.b.iv for the inclusion of triggers in WRPs and in I.2.b.v for the inclusion of high risk status and RM Committee recommendations in WRPs, the facility has an effective mechanism in place to advise WRPTs that an individual has reached these thresholds.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
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, March 2010:</b> Continue current practice, including monitoring for incorporation of risks and incidents and triggers into WRPs.</p> <p><b>Findings:</b> As reported below, 13 triggers were sampled, and all were found to be</p>

Section I: Protection from Harm

		<p>referenced in the individual's WRP.</p> <table border="1" data-bbox="955 266 1885 915"> <thead> <tr> <th>Individual</th> <th>Approximate date of trigger</th> <th>Addressed/cited in WRP?</th> </tr> </thead> <tbody> <tr> <td colspan="3"><b>Trigger: Aggression to self resulting in major injury</b></td> </tr> <tr> <td>JH</td> <td>6/14/10</td> <td>Cited in WRP 8/9/10</td> </tr> <tr> <td></td> <td>7/2/10</td> <td>Cited in WRP 8/9/10</td> </tr> <tr> <td>JLS</td> <td>7/12/10</td> <td>Cited in WRP 8/26/10</td> </tr> <tr> <td>JC</td> <td>7/15/10</td> <td>Cited in WRP 8/16/10</td> </tr> <tr> <td colspan="3"><b>Multiple Triggers</b></td> </tr> <tr> <td>JR</td> <td colspan="2">WRP 7/8/10 cites all triggers for June</td> </tr> <tr> <td>SC</td> <td colspan="2">WRP 8/12/10 cites all triggers for June</td> </tr> <tr> <td colspan="3"><b>Trigger: Suicide attempt/threat</b></td> </tr> <tr> <td>VC</td> <td>4/23/10</td> <td>Cited in 6/10 WRP</td> </tr> <tr> <td>CG</td> <td>7/8/10</td> <td>Cited in 7/9/10 WRP</td> </tr> <tr> <td colspan="3"><b>Trigger: 2 or more aggressive acts to others in 7 days</b></td> </tr> <tr> <td>VC</td> <td>5/5, 6/16, 7/4</td> <td>Cited in 8/9/10 WRP</td> </tr> <tr> <td colspan="3"><b>Trigger: 4 or more aggressive acts to others in 30 days</b></td> </tr> <tr> <td>VC</td> <td>5/10, 6/27</td> <td>Cited in 8/9/10 WRP</td> </tr> </tbody> </table> <p>The findings reported above are consistent with the facility's internal audits, which found that the action proposed by the WRPT in response to triggers was implemented in 92-95% of the cases audited.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring.</p>	Individual	Approximate date of trigger	Addressed/cited in WRP?	<b>Trigger: Aggression to self resulting in major injury</b>			JH	6/14/10	Cited in WRP 8/9/10		7/2/10	Cited in WRP 8/9/10	JLS	7/12/10	Cited in WRP 8/26/10	JC	7/15/10	Cited in WRP 8/16/10	<b>Multiple Triggers</b>			JR	WRP 7/8/10 cites all triggers for June		SC	WRP 8/12/10 cites all triggers for June		<b>Trigger: Suicide attempt/threat</b>			VC	4/23/10	Cited in 6/10 WRP	CG	7/8/10	Cited in 7/9/10 WRP	<b>Trigger: 2 or more aggressive acts to others in 7 days</b>			VC	5/5, 6/16, 7/4	Cited in 8/9/10 WRP	<b>Trigger: 4 or more aggressive acts to others in 30 days</b>			VC	5/10, 6/27	Cited in 8/9/10 WRP
Individual	Approximate date of trigger	Addressed/cited in WRP?																																																
<b>Trigger: Aggression to self resulting in major injury</b>																																																		
JH	6/14/10	Cited in WRP 8/9/10																																																
	7/2/10	Cited in WRP 8/9/10																																																
JLS	7/12/10	Cited in WRP 8/26/10																																																
JC	7/15/10	Cited in WRP 8/16/10																																																
<b>Multiple Triggers</b>																																																		
JR	WRP 7/8/10 cites all triggers for June																																																	
SC	WRP 8/12/10 cites all triggers for June																																																	
<b>Trigger: Suicide attempt/threat</b>																																																		
VC	4/23/10	Cited in 6/10 WRP																																																
CG	7/8/10	Cited in 7/9/10 WRP																																																
<b>Trigger: 2 or more aggressive acts to others in 7 days</b>																																																		
VC	5/5, 6/16, 7/4	Cited in 8/9/10 WRP																																																
<b>Trigger: 4 or more aggressive acts to others in 30 days</b>																																																		
VC	5/10, 6/27	Cited in 8/9/10 WRP																																																
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Remind WRPTs of the requirement to reference recommendations made by the ETRC either by implementing the recommendation or providing a</p>																																																

Section I: Protection from Harm

		<p>rationale for not implementing it. This requirement is clearly delineated in the facility's directions to WRPTs entitled "Documenting Risk Factors, Triggers and Risk Management Committee Recommendations in the WRP."</p> <p><b>Findings:</b> As shown in the table below, 20 of 22 recommendations (91%) made by Risk Management committees were addressed in the individual's WRP.</p> <p><b>Recommendation 2, March 2010:</b> Continue WRPTs' practice of referencing triggers and their response in the following WRP.</p> <p><b>Findings:</b> Please see findings in the cell above.</p> <p><b>Other findings:</b></p> <table border="1" data-bbox="953 821 1894 1424"> <thead> <tr> <th>Individual</th> <th>High Risk Category</th> <th>Cited in WRP as Risk Factor?</th> <th>Addressed in WRP? Date and Focus.</th> </tr> </thead> <tbody> <tr> <td>CC</td> <td>Victimization</td> <td>Yes</td> <td>8/9/10 Focus 3.1</td> </tr> <tr> <td>IH</td> <td>Victimization</td> <td>Yes</td> <td>7/14/10 No focus</td> </tr> <tr> <td>MM</td> <td>Victimization</td> <td>Yes</td> <td>8/9/10 Focus 1.1</td> </tr> <tr> <td>JR</td> <td>Victimization</td> <td>Yes</td> <td>8/26/10 Focus 3.1</td> </tr> <tr> <td>LD</td> <td>Victimization</td> <td>Yes</td> <td>8/17/10 No focus</td> </tr> <tr> <td>NK</td> <td>Victimization</td> <td>Yes</td> <td>8/23/10 Focus 1.3</td> </tr> <tr> <td>BB</td> <td>Victimization</td> <td>Yes</td> <td>7/29/10 No focus. Given additional assistance on the unit and in finding her Mall groups.</td> </tr> <tr> <td>SC</td> <td>Victimization</td> <td>Yes</td> <td>8/10/10 No focus. Placed on 1:1 &amp; aggressor moved to another unit.</td> </tr> <tr> <td>JL</td> <td>Victimization</td> <td>Yes</td> <td>8/5/10. No focus. Moved</td> </tr> </tbody> </table>	Individual	High Risk Category	Cited in WRP as Risk Factor?	Addressed in WRP? Date and Focus.	CC	Victimization	Yes	8/9/10 Focus 3.1	IH	Victimization	Yes	7/14/10 No focus	MM	Victimization	Yes	8/9/10 Focus 1.1	JR	Victimization	Yes	8/26/10 Focus 3.1	LD	Victimization	Yes	8/17/10 No focus	NK	Victimization	Yes	8/23/10 Focus 1.3	BB	Victimization	Yes	7/29/10 No focus. Given additional assistance on the unit and in finding her Mall groups.	SC	Victimization	Yes	8/10/10 No focus. Placed on 1:1 & aggressor moved to another unit.	JL	Victimization	Yes	8/5/10. No focus. Moved
Individual	High Risk Category	Cited in WRP as Risk Factor?	Addressed in WRP? Date and Focus.																																							
CC	Victimization	Yes	8/9/10 Focus 3.1																																							
IH	Victimization	Yes	7/14/10 No focus																																							
MM	Victimization	Yes	8/9/10 Focus 1.1																																							
JR	Victimization	Yes	8/26/10 Focus 3.1																																							
LD	Victimization	Yes	8/17/10 No focus																																							
NK	Victimization	Yes	8/23/10 Focus 1.3																																							
BB	Victimization	Yes	7/29/10 No focus. Given additional assistance on the unit and in finding her Mall groups.																																							
SC	Victimization	Yes	8/10/10 No focus. Placed on 1:1 & aggressor moved to another unit.																																							
JL	Victimization	Yes	8/5/10. No focus. Moved																																							



Section I: Protection from Harm

			staff. Referral for PT assessment made on 4/23/10, and screen completed with recommendations for physical supports on 4/30/10 including helmet, but full assessment not completed.
		VMC	New diagnosis of diabetes The WRP dated 6/7/10 listed R/O DM as an Axis III diagnosis. Focus 6.4 addresses DM but is not open; listed as health maintenance. Dietitian assessment dated 4/14/10 addressed diabetes symptoms and made recommendations for weight and glucose stabilization. Nutrition update on 7/1/10 addressed diabetes diagnosis but stated that individual was refusing labs.
		MKN	New diagnosis of diabetes The WRP dated 6/11/10 has DM listed as an Axis III diagnosis; focus 6.3 objectives and intervention in place for diabetes management by nurse and dietitian. No evidence of Nutrition assessment following DM diagnosis was found.
		DM	New diagnosis of diabetes The WRP dated 4/13/10 stated treatment for diabetes began on 4/01/10; listed as Axis III diagnosis; focus 6.12 objective and intervention in place for metabolic syndrome.
		MN	Diagnosis of diabetes WRP dated 6/29/10 lists DM as Axis III diagnosis as documented on 4/30/10. Open focus 6.3 for DM with objectives and interventions for dietitian and nursing staff. Nutrition assessments dated 5/6/10 and 7/30/10 addressed

Section I: Protection from Harm

			symptoms and contributing factors.
		RCF	Decubitus ulcer stage III upon admission on 4/6/10  WRP dated 7/7/10 described location, staging and treatment for decubitus, and open focus 6.3 for decubitus noted. No referral to OT or PT to assess and address positioning for pressure reduction noted, although this appeared to be indicated as individual was in wheelchair, has compromised mobility and sensation, and decubitus unresolved.
		REG	At high risk for metabolic syndrome  Dietitian assessments 6/26/10 and 8/18/10 provided recommendations to address contributing risk factors of obesity, hypertension and hyperlipidemia. High risk identified in the present status of the WRP dated 7/10/10; open foci 6.3 for obesity, 6.2 for hypercholesterolemia and 6.1 for hypertension. Dietitian objective 6.4.1 and intervention 6.4.1.6 in place to address obesity.
		GABM	At high risk for metabolic syndrome  Dietitian assessment 7/20/10 provided recommendations to address contributing risk factors of obesity and hyperlipidemia. High risk identified in present status of WRP dated 7/16/10; open foci 6.5 for obesity and 6.2 for hyperlipidemia. Dietitian objectives 6.2.2.4 and 6.2.4.1 and interventions in place to address hyperlipidemia; 6.5.1 objective and RD and nursing interventions in place to address obesity.
		GYG	At high risk for metabolic syndrome  High risk identified in the present status of the WRP dated 8/13/10. Dietitian

Section I: Protection from Harm

			assessment completed on 7/23/10 focused on obesity and made recommendations for weight loss objective but was not included in the WRP. Open foci 6.1 for obesity and 6.7 for dyslipidemia.
		KG	At high risk for impaired skin integrity High risk identified in the present status of the WRP dated 7/29/10; no open focus to address risk. Individual in RNA program for home exercises for ambulation but no evidence of POST referral due to risk for impaired skin integrity.
		JJW	At high risk for impaired skin integrity High risk not identified in the present status of the most recent WRP dated 8/19/10.
		VF	At high risk for impaired skin integrity High risk not identified in the present status of the most recent WRP dated 8/20/10.
		EL	At high risk for choking Speech therapy quarterly review completed 6/8/10. High risk identified in the present status of WRP dated 7/6/10, with 6.4 objective and intervention in place to address risk. However, due to recommended assistance and compensatory techniques, it appears that the individual would meet criteria for a 24-hour support plan to promote safety and independence, though no plan was developed and implemented.
		DC	At high risk for choking High risk identified in the present status of the most recent WRP dated 7/8/10, with 6.19 objective and intervention in

Section I: Protection from Harm

				<p>place to address risk. A referral for Speech Therapy assessment was written on 5/25/10 and although evidence of quarterly reassessments was found on 6/2/10 and 8/30/10, no evidence of SLP assessment was found in the record. The treatment plan stated the individual had a 24-hour plan to address choking risk and mealtime support needs, but this plan was not found in the record.</p>												
<p>All recommendations made by the FRC, ETRC and MRMC are supported by a rationale documented in the committee minutes.</p>																
<table border="1"> <thead> <tr> <th data-bbox="953 716 1085 789">Individual</th> <th data-bbox="1085 716 1493 789">Committee--date Recommendations</th> <th data-bbox="1493 716 1908 789">WRPT response</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 789 1085 1049">MP</td> <td data-bbox="1085 789 1493 1049"> <p>FRC--2/25/10</p> <p>Arrange a family meeting</p> <p>Provide an IT assignment as a co-leader in Spanish group</p> </td> <td data-bbox="1493 789 1908 1049"> <p>WRP 3/26/10 cites FRC review</p> <p>Meeting held</p> <p>IT assignment in Program II is in process.</p> </td> </tr> <tr> <td data-bbox="953 1049 1085 1344">CP</td> <td data-bbox="1085 1049 1493 1344"> <p>ETRC--6/8/10</p> <p>Engage aunt/conservator</p> <p>Undertake diagnosis clarification.</p> <p>Remove reference to delusions in Focus 1.</p> </td> <td data-bbox="1493 1049 1908 1344"> <p>WRP 7/20/10 shows communication with aunt</p> <p>WRP 7/20 shows change in diagnosis. .</p> <p>Focus 1 in WRP 7/20 has no reference to delusions</p> </td> </tr> <tr> <td data-bbox="953 1344 1085 1416">VC</td> <td data-bbox="1085 1344 1493 1416"> <p>FRC--7/29/10</p> </td> <td data-bbox="1493 1344 1908 1416"> <p>WRP 8/9/10 cites the FRC review and all</p> </td> </tr> </tbody> </table>					Individual	Committee--date Recommendations	WRPT response	MP	<p>FRC--2/25/10</p> <p>Arrange a family meeting</p> <p>Provide an IT assignment as a co-leader in Spanish group</p>	<p>WRP 3/26/10 cites FRC review</p> <p>Meeting held</p> <p>IT assignment in Program II is in process.</p>	CP	<p>ETRC--6/8/10</p> <p>Engage aunt/conservator</p> <p>Undertake diagnosis clarification.</p> <p>Remove reference to delusions in Focus 1.</p>	<p>WRP 7/20/10 shows communication with aunt</p> <p>WRP 7/20 shows change in diagnosis. .</p> <p>Focus 1 in WRP 7/20 has no reference to delusions</p>	VC	<p>FRC--7/29/10</p>	<p>WRP 8/9/10 cites the FRC review and all</p>
Individual	Committee--date Recommendations	WRPT response														
MP	<p>FRC--2/25/10</p> <p>Arrange a family meeting</p> <p>Provide an IT assignment as a co-leader in Spanish group</p>	<p>WRP 3/26/10 cites FRC review</p> <p>Meeting held</p> <p>IT assignment in Program II is in process.</p>														
CP	<p>ETRC--6/8/10</p> <p>Engage aunt/conservator</p> <p>Undertake diagnosis clarification.</p> <p>Remove reference to delusions in Focus 1.</p>	<p>WRP 7/20/10 shows communication with aunt</p> <p>WRP 7/20 shows change in diagnosis. .</p> <p>Focus 1 in WRP 7/20 has no reference to delusions</p>														
VC	<p>FRC--7/29/10</p>	<p>WRP 8/9/10 cites the FRC review and all</p>														

Section I: Protection from Harm

			<p>gather information about twin.</p> <p>Make specific medication changes.</p> <p>Contact prior treatment facilities for information.</p>	<p>recommendations.</p> <p>SW spoke with family.</p> <p>Not implemented and no rationale provided.</p> <p>WRP 8/9/10. Regional Center contacted re: prior services.</p>
		SC	<p>FRC--7/15/10 Order an MRI.</p> <p>Conduct psychological testing to R/O malingering.</p> <p>Resume implementation of Behavioral Guidelines</p>	<p>CT scan completed at Norwalk Hospital. Negative. Seen by neurologist on 7/21/10.</p> <p>Referrals made on 7/16 and 8/4.</p> <p>Rationale provided for no implementation: individual acknowledged malingering.</p>
		NK	<p>ETRC--3/30/10 Reduce and discontinue a specific medication.</p>	<p>WRP 4/27/10. Medication discontinued.</p>
		OC	<p>ETRC--6/15/10 Transfer to Unit 414.</p>	<p>Transfer completed on 6/17/10.</p>
		CW	<p>FRC--6/17/10 Question etiology of seizures.</p>	<p>WRP 7/20/10 Seizure evaluation completed and seizure medication changed.</p>
		HC	<p>FRC--4/15/10 Clarify Axis 1 diagnosis</p>	<p>Not addressed in WRP 4/15</p>

Section I: Protection from Harm

			<p>Re-refer for neuro-psychological testing</p> <p>MRMC 3/3/10 Refer for hearing assessment</p>	<p>or 8/9/10.</p> <p>Referred on 6/3/10.</p> <p>Referral completed on 4/12/10.</p>
		<p>SM</p>	<p>ETRC--4/10/10 Develop Behavior Guidelines</p> <p>FRC--5/20/10 Discontinue specific medication Get serum level for specific medication Increase activities Develop other incentives, e.g. Chinese food</p>	<p>BGs developed on 4/22/10.</p> <p>All FRC recommendations were addressed in the 5/27/10 WRP.</p>
		<p>In addition to auditing WRPs for implementation of recommendations made by Risk Management Committees, the facility is tracking the outcome for individuals who are reviewed by the MRMC. The facility reported the medical issue and the outcome following the review for 19 individuals. For example, of the four individuals with risks related to diabetes, one was discharged, two remained inconsistent in accepting treatment, and one has adhered to his/her treatment regimen.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Continue current practice and monitoring during the maintenance phase.</li> <li>2. Address the need to ensure that full evaluations follow when screenings</li> </ol>		

Section I: Protection from Harm

		indicate.
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, March 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> In an interview, the Clinical Administrator outlined actions planned to improve care at the unit level. These include:</p> <ul style="list-style-type: none"> <li>• Efforts directed at reducing the facility's reliance on overtime (a statewide issue), including its relationship to the use of FMLA;</li> <li>• Changing staff schedules to ensure that a regular Shift Lead is present on one of two units each weekend day;</li> <li>• Clarifying for all staff that sleeping on duty is neglect and will be a cause for action;</li> <li>• Holding staff and supervisors accountable for following the assignment sheets;</li> <li>• Development of an "Acting Shift Lead" orientation packet;</li> <li>• Providing additional competency training annually for nurses and providing a longer mentoring period during nursing orientation; and</li> <li>• Incidents resulting in an injury requiring medical care will go to OSI immediately.</li> </ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue the work necessary to bring the facility into substantial compliance with the EP and maintain substantial compliance-level performance.</p>

Section I: Protection from Harm

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. M. Hamilton, Health and Safety Officer</li> </ol> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> <li>1. Environment of Care Suicide Prevention Status Report</li> <li>2. WRPs of 12 individuals with the problem of incontinence.</li> <li>3. Clinical records of six individuals involved in sexual incidents</li> <li>4. Program Management Rounds Records</li> </ol> <p><u>Toured:</u></p> <ol style="list-style-type: none"> <li>1. Five units: 407, 408, 410, 412 and 416</li> <li>2. Former Children's Building being renovated for CT-West</li> </ol>
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, March 2010:</b> Provide individuals at choking risk with appropriate supervision and assistance at meals.</p> <p><b>Findings:</b> Reviewers found no individuals without adequate supervision and assistance during mealtime observations.</p> <p><b>Recommendation 2, March 2010:</b> Continue implementing plans to improve the safety of the environment as resources permit.</p>

Section I: Protection from Harm

		<p><b>Findings:</b></p> <p>The facility is renovating the 100 Units (former Children's Building) where it plans to move the LPS individuals. When completed, this building will provide a pleasant and secure environment. Renovations include, but are not limited to, restroom partition and toilet replacements, second means of egress from some nursing stations, replacement of asbestos tiles, and door replacement in fire corridors. During our tour this monitor observed these renovations. Restroom partitions rise to the ceiling, but are transparent above head level, so that rescuers can see what is occurring in a stall if there is an emergency.</p> <p>The current status and approximate cost of 22 initiatives to increase the safety of the environment was provided in the MSH Environment of Care Suicide Prevention Status Report. A selected sample is described below.</p> <table border="1" data-bbox="953 708 1860 1416"> <thead> <tr> <th>Project</th> <th>Description</th> <th>Current status</th> <th>Projected completion</th> </tr> </thead> <tbody> <tr> <td>Pan beds</td> <td>Replace spring beds</td> <td>572 beds installed. 140 to be purchased, pending budget approval</td> <td>9/1/10</td> </tr> <tr> <td>Restroom partitions</td> <td>Replace partitions with those with no support poles or open areas</td> <td>Project complete in the 100 units (former Children's Bldg.)</td> <td>Yet to be determined</td> </tr> <tr> <td>Shower grab bars</td> <td>Replace with no open area grab bars</td> <td>Complete throughout MSH except in the SNF unit.</td> <td>9/10</td> </tr> <tr> <td>Wardrobe replacement</td> <td>Eliminate tall wardrobes</td> <td>Most units completed.</td> <td>Will complete when CT West moves to the</td> </tr> </tbody> </table>	Project	Description	Current status	Projected completion	Pan beds	Replace spring beds	572 beds installed. 140 to be purchased, pending budget approval	9/1/10	Restroom partitions	Replace partitions with those with no support poles or open areas	Project complete in the 100 units (former Children's Bldg.)	Yet to be determined	Shower grab bars	Replace with no open area grab bars	Complete throughout MSH except in the SNF unit.	9/10	Wardrobe replacement	Eliminate tall wardrobes	Most units completed.	Will complete when CT West moves to the
Project	Description	Current status	Projected completion																			
Pan beds	Replace spring beds	572 beds installed. 140 to be purchased, pending budget approval	9/1/10																			
Restroom partitions	Replace partitions with those with no support poles or open areas	Project complete in the 100 units (former Children's Bldg.)	Yet to be determined																			
Shower grab bars	Replace with no open area grab bars	Complete throughout MSH except in the SNF unit.	9/10																			
Wardrobe replacement	Eliminate tall wardrobes	Most units completed.	Will complete when CT West moves to the																			

Section I: Protection from Harm

					100s. Additional collars ready for installation
Fire strobes	Install collars in non-visible patient areas	Completed in all bedrooms and dorms. Will install in hallways		Ceiling light fixtures	Seal space between ceiling and fixture
Shower heads & shower controls	Replace with push button controls and snubbed shower heads	Replacements completed in all treatment areas.		Replace porcelain toilets	Replace with stainless steel ones in high risk areas.
		Replacement completed on several units and in the 100 Building under renovation		<p>Program Managers have increased their on-unit presence and while doing so complete a 28-item checklist. In addition to reviewing environmental conditions, the checklist queries staffing issues related to assignments, position/location on the unit, rounds, interactions with individuals and supervision provided by the Shift Lead. The checklists for August cited environmental findings that required correction and many instances of activity schedules that were not current. Single, specific finding related to one unit at a particular time included finding one individual naked in the dayhall and one naked in the hallway, two of three staff on break during the PM shift, one staff found sleeping, and hourly rounds incomplete.</p> <p><b>Other findings:</b> Inattention to obvious safety risks was evident in several observations made during the tour of the units. Specifically:</p>	

Section I: Protection from Harm

		<ul style="list-style-type: none"><li>• On Unit 412 a woman (LW) was lying on a couch in the dayroom wearing no clothes and covered only with a sheet. Two men were also in the dayroom and no staff were present in the room or supervising the room from the nurses' station. All three individuals were placed at risk. When this was pointed out, staff intervened and escorted LW to her room and helped her dress.</li><li>• The cut-down instrument on this unit was kept in a drawer that one would describe as a junk drawer. The staff member looking for the instrument had to move papers and other objects to find the hook-shaped cutter.</li><li>• In one bathroom on Unit 407, a shower seat is located directly under a vent. Facility escorts agreed to move the seat. Additionally, the escorts agreed to check the shower regulator valve in the bathroom to see if it would support a ligature, given the placement of the shower grab bar beneath it.</li></ul> <p>The additional observations below were made during the tour of the five occupied units:</p> <ul style="list-style-type: none"><li>• The dayroom on Unit 408 (used only as a Mall area; no individuals live on this unit) was furnished with only five plastic patio chairs. At the time of the observation, two individuals and one staff member were sitting and one individual was lying on the floor. He moved to a chair when requested by staff.</li><li>• The night rounds sheet for the night prior to the observation was completed for each 30 minute check on Unit 410. Working flashlights were accessible.</li><li>• A bedroom on Unit 416 had a non-functional thermostat that presented a self-harm hazard. Facility escorts agreed to have this removed immediately. Flashlights for making night rounds were operational on this unit. The cut-down instrument (a pair of scissors) was kept in a drawer in the nurses' station.</li></ul>
--	--	---

Section I: Protection from Harm

		<ul style="list-style-type: none"> <li>Several individuals were provided incontinent beds on Unit 412. The impermeable flooring in the rooms for individuals with the problem of incontinence also contributed positively to the environment.</li> </ul> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendations:</b></p> <ol style="list-style-type: none"> <li>1. 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.</li> <li>2. 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.</li> <li>3. 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.</li> </ol>
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, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> All areas toured were a comfortable temperature.</p> <p><b>Other findings:</b> The facility reported that all temperature variation situations were corrected on the same day the work order is received.</p> <p><b>Compliance:</b> Substantial.</p>

Section I: Protection from Harm

		<p><b>Current recommendation:</b> Continue current practice.</p>																												
I.3.c	<p>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>	<p><b>Current findings on previous recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice.</p> <p><b>Findings:</b> During the report period, the facility's monitoring of individuals with the problem of incontinence yielded the following results</p> <table border="1" data-bbox="955 673 1890 901"> <thead> <tr> <th>Criterion</th> <th>Compliance rate</th> </tr> </thead> <tbody> <tr> <td>Incontinence status is addressed in Present Status</td> <td>65%</td> </tr> <tr> <td>Incontinence identified in Focus 6</td> <td>62%</td> </tr> <tr> <td>Objectives promote dignity and self-reliance</td> <td>29%</td> </tr> <tr> <td>Individual is clean, dry and odor-free.</td> <td>94%</td> </tr> <tr> <td>Nursing staff explain how they assist the individual</td> <td>91%</td> </tr> </tbody> </table> <p><b>Other findings:</b> The WRPs of all 12 individuals sampled who have the problem of incontinence addressed the issue in Focus 6 with objectives and interventions.</p> <table border="1" data-bbox="955 1088 1360 1388"> <thead> <tr> <th>Individual</th> <th>Focus 6</th> </tr> </thead> <tbody> <tr> <td>EA</td> <td>6.17</td> </tr> <tr> <td>MB</td> <td>6.12</td> </tr> <tr> <td>MC</td> <td>6.5</td> </tr> <tr> <td>AD</td> <td>6.9</td> </tr> <tr> <td>VF</td> <td>6.9</td> </tr> <tr> <td>JG</td> <td>6.5</td> </tr> <tr> <td>MJ</td> <td>6.4</td> </tr> </tbody> </table>	Criterion	Compliance rate	Incontinence status is addressed in Present Status	65%	Incontinence identified in Focus 6	62%	Objectives promote dignity and self-reliance	29%	Individual is clean, dry and odor-free.	94%	Nursing staff explain how they assist the individual	91%	Individual	Focus 6	EA	6.17	MB	6.12	MC	6.5	AD	6.9	VF	6.9	JG	6.5	MJ	6.4
Criterion	Compliance rate																													
Incontinence status is addressed in Present Status	65%																													
Incontinence identified in Focus 6	62%																													
Objectives promote dignity and self-reliance	29%																													
Individual is clean, dry and odor-free.	94%																													
Nursing staff explain how they assist the individual	91%																													
Individual	Focus 6																													
EA	6.17																													
MB	6.12																													
MC	6.5																													
AD	6.9																													
VF	6.9																													
JG	6.5																													
MJ	6.4																													

Section I: Protection from Harm

		<table border="1"> <tr> <td>JL</td> <td>6.5</td> </tr> <tr> <td>DM</td> <td>6.4</td> </tr> <tr> <td>FR</td> <td>6.8</td> </tr> <tr> <td>SS</td> <td>6.4</td> </tr> <tr> <td>ST</td> <td>6.4</td> </tr> </table>	JL	6.5	DM	6.4	FR	6.8	SS	6.4	ST	6.4	<p>These findings are more positive than those reported by the facility. In the period February-July 2010, the facility found that incontinence was identified in Focus 6 in 62% of the WRPs sampled. Significantly, the facility found that 94% of the individuals in its sample were observed to be clean and odor-free and dressed in clean, dry clothing.</p> <p><b>Compliance:</b> Substantial.</p> <p><b>Current recommendation:</b> Continue current practice.</p>
JL	6.5												
DM	6.4												
FR	6.8												
SS	6.4												
ST	6.4												
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 recommendation:</b></p> <p><b>Recommendation, March 2010:</b> Continue current practice and ensure individuals receive appropriate counseling.</p> <p><b>Findings:</b> This monitor reviewed the following charts:</p>	<table border="1"> <thead> <tr> <th>Individual</th> <th>Incident type</th> <th>Response</th> </tr> </thead> <tbody> <tr> <td>CG 3/8/10</td> <td>Sexual assault Victim</td> <td>Claims peer held her down while he removed her clothing and engaged in sexual acts that did not involve penetration.</td> </tr> </tbody> </table>	Individual	Incident type	Response	CG 3/8/10	Sexual assault Victim	Claims peer held her down while he removed her clothing and engaged in sexual acts that did not involve penetration.				
Individual	Incident type	Response											
CG 3/8/10	Sexual assault Victim	Claims peer held her down while he removed her clothing and engaged in sexual acts that did not involve penetration.											

Section I: Protection from Harm

			HPO and psychiatrist notified.
RS 3/8/10	Sexual assault Aggressor		Denied use of force. Said victim offered sexual favors in exchange for cigarettes. Incident investigated by HPO.
HC 5/8/10	Sexual assault Victim		Claims sexually assaulted by peer. Assessed by RN who found bruises to arms and chest. Referred to Rape Clinic.
OD 6/15/10	Sexual abuse Victim		Staff member accused of offering sexual favors to several individuals. This staff member was removed from contact with individuals. Investigation begun.
TC 7/22/10	Sexual assault Victim		Sexual assault claim alternated with claim that activity was consensual. No psychological trauma apparent, per RN note. Sent to Rape Clinic.
BL 7/22/10	Sexual assault Aggressor		IDN note 7/27/10 cites individual's denial of any sexual contact.
<p>During the review period, the facility audited a total of 46 sexual incidents and reported that in all instances the incident and the actions taken were documented in the chart; a medical assessment was completed in 60% of the incidents and a psychological assessment was completed in 65%. The facility found that in 95% of the incidents, the individual was provided sexual education. This last finding is not consistent with chart review findings.</p> <p><b>Compliance:</b> Substantial.</p>			

Section I: Protection from Harm

		<p><b>Current recommendation:</b> Continue to monitor compliance with this portion of the EP.</p>																		
<p>I.3.e</p>	<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, March 2010:</b> Ensure that as new staff members take on responsibility for leading Mall groups, they receive the training curriculum.</p> <p><b>Findings:</b> See the findings below.</p> <p><b>Other findings:</b> The facility reported the following training completion rates a year ago:</p> <table border="1" data-bbox="955 784 1575 1166"> <thead> <tr> <th>Course</th> <th>Nov 2008—Apr 2009</th> </tr> </thead> <tbody> <tr> <td>PMAB</td> <td>94%</td> </tr> <tr> <td>CPR</td> <td>88%</td> </tr> <tr> <td>First Aid</td> <td>94%</td> </tr> <tr> <td>Recovery (Chapter 1)</td> <td>79%</td> </tr> <tr> <td>By Choice</td> <td>87%</td> </tr> <tr> <td>Patients Rights</td> <td>88%</td> </tr> <tr> <td>Neglect and Abuse</td> <td>94%</td> </tr> <tr> <td>Mean Compliance Rate</td> <td>87%</td> </tr> </tbody> </table> <p>The facility reported that by the close of the current review period, all staff had been appropriately trained. The facility used two data sources to identify the training needs, if any, of each staff member and to monitor their attendance at training.</p>	Course	Nov 2008—Apr 2009	PMAB	94%	CPR	88%	First Aid	94%	Recovery (Chapter 1)	79%	By Choice	87%	Patients Rights	88%	Neglect and Abuse	94%	Mean Compliance Rate	87%
Course	Nov 2008—Apr 2009																			
PMAB	94%																			
CPR	88%																			
First Aid	94%																			
Recovery (Chapter 1)	79%																			
By Choice	87%																			
Patients Rights	88%																			
Neglect and Abuse	94%																			
Mean Compliance Rate	87%																			

Section I: Protection from Harm

		<p><b>Compliance:</b> Substantial, based on facility information.</p> <p><b>Current recommendation:</b> Continue current practice and monitoring during the maintenance phase.</p>
--	--	--

Section J: First Amendment and Due Process

<b>J. First Amendment and Due Process</b>		
J		<p><b>Summary of Progress:</b></p> <ol style="list-style-type: none"> <li>1. Although the leadership of the Senate has changed, the meetings continue to be characterized by the focused and respectful exchange of information. Individuals acknowledge and thank staff for improvements in operations, as well as voice concerns. Individuals respond to questions asking for clarification in an appropriate manner and listen to each other without interruption.</li> <li>2. Facility staff in leadership roles attend the meetings and address concerns as they are voiced. When solutions cannot be implemented immediately, facility staff identify who will be responsible for reporting back to the Council.</li> <li>3. Council members carry old business through to its conclusion, which on items such as the Allowables List, can last months.</li> </ol>
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.	<p><b>Methodology:</b></p> <p><u>Interviewed:</u> Several individuals during unit tours</p> <p><u>Reviewed:</u> Individual Council Survey results</p> <p><u>Observed:</u> Senate Council meeting</p>
J		<p><b>Current findings on previous recommendations:</b></p> <p><b>Recommendation 1, March 2010:</b> Continue work on the Allowables List.</p>

		<p><b>Findings:</b>  DMH is still developing a statewide Allowables List. Presently individuals who have certain types of electronic equipment (CD players, for example) are permitted to keep them. Individuals are not allowed to purchase these same items, however. This has created a "have" and "have not" split among individuals that does not support a peaceful environment. Both the facility and DMH acknowledge this problem, and DMH will continue to work on an Allowables List.</p> <p><b>Recommendation 2, March 2010:</b>  Continue providing a safe forum in the Council and Senate meetings for individuals to voice their concerns.</p> <p><b>Findings:</b>  Individuals freely and respectfully expressed their concerns at the Senate meeting, which was attended by the Executive Director and others in facility leadership positions. Concerns expressed included:</p> <ul style="list-style-type: none"> <li>• The problem with toothbrushes. It is difficult to adequately clean one's teeth with the thumb-sized toothbrushes that are supplied for security reasons.</li> <li>• Some units appear to make their own rules about the electronics that are allowable. Individuals reported that a piece of equipment may be approved by the HPD, but when it is delivered to the unit, supervisors forbid its use.</li> <li>• Hard-boiled eggs were taken off the menu reportedly because they posed a safety hazard. What hazard? Same question as related to salt shakers.</li> <li>• Can food selections for vegetarians be increased?</li> </ul> <p>The facility agreed to set up a separate meeting to discuss with individuals their concerns about pain control. The facility leadership also said it would work on incorporating into the next Mall cycle groups dealing with conflict</p>
--	--	--

Section J: First Amendment and Due Process

		<p>resolution, coping skills and peer support.</p> <p>At the meeting individuals said they were pleased to have evening enrichment activities and hoped these would be expanded.</p> <p><b>Other findings:</b> This survey is available to individuals in both English and Spanish.</p> <table border="1" data-bbox="961 487 1896 1282"> <thead> <tr> <th rowspan="2">Item</th> <th colspan="2">Percentage of positive responses</th> </tr> <tr> <th>January 2010</th> <th>July 2010</th> </tr> </thead> <tbody> <tr> <td>Feel safe?</td> <td>74%</td> <td>70%</td> </tr> <tr> <td>Treated with respect?</td> <td>86%</td> <td>87%</td> </tr> <tr> <td>Environment clean?</td> <td>77%</td> <td>78%</td> </tr> <tr> <td>Have access to personal hygiene supplies?</td> <td>90%</td> <td>87%</td> </tr> <tr> <td>Assisted in meeting wellness and recovery goals?</td> <td>81%</td> <td>83%</td> </tr> <tr> <td>Able to communicate freely w/ family, attorneys and advocates?</td> <td>84%</td> <td>78%</td> </tr> <tr> <td>Taught what constitutes abuse and neglect?</td> <td>64%</td> <td>69%</td> </tr> <tr> <td>Can report abuse/neglect?</td> <td>84%</td> <td>81%</td> </tr> <tr> <td>Staff tried to calm you prior to using seclusion or restraints?</td> <td>76%</td> <td>81%</td> </tr> <tr> <td>Released from restraint/seclusion when calm?</td> <td>86%</td> <td>89%</td> </tr> <tr> <td>Taught about medications, results and common and serious side effects?</td> <td>71%</td> <td>70%</td> </tr> </tbody> </table> <p><b>Compliance:</b> Substantial.</p>	Item	Percentage of positive responses		January 2010	July 2010	Feel safe?	74%	70%	Treated with respect?	86%	87%	Environment clean?	77%	78%	Have access to personal hygiene supplies?	90%	87%	Assisted in meeting wellness and recovery goals?	81%	83%	Able to communicate freely w/ family, attorneys and advocates?	84%	78%	Taught what constitutes abuse and neglect?	64%	69%	Can report abuse/neglect?	84%	81%	Staff tried to calm you prior to using seclusion or restraints?	76%	81%	Released from restraint/seclusion when calm?	86%	89%	Taught about medications, results and common and serious side effects?	71%	70%
Item	Percentage of positive responses																																							
	January 2010	July 2010																																						
Feel safe?	74%	70%																																						
Treated with respect?	86%	87%																																						
Environment clean?	77%	78%																																						
Have access to personal hygiene supplies?	90%	87%																																						
Assisted in meeting wellness and recovery goals?	81%	83%																																						
Able to communicate freely w/ family, attorneys and advocates?	84%	78%																																						
Taught what constitutes abuse and neglect?	64%	69%																																						
Can report abuse/neglect?	84%	81%																																						
Staff tried to calm you prior to using seclusion or restraints?	76%	81%																																						
Released from restraint/seclusion when calm?	86%	89%																																						
Taught about medications, results and common and serious side effects?	71%	70%																																						

Section J: First Amendment and Due Process

		<p><b>Current recommendations:</b></p> <ol style="list-style-type: none"><li>1. Continue work on the Allowables List.</li><li>2. As planned, address the issue of pain control with the Council</li><li>3. Direct attention to the survey finding that suggests a number of individuals report they have not been taught what constitutes abuse and neglect.</li></ol>
--	--	--