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State of California—Health and Human Services Agency
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SONOMA DEVELOPMENTAL CENTER
PROGRAM IMPROVEMENT PLAN

Preamble

This Program Improvement Plan (referenced herein as “PIP” and/or “the Agreement”) is between the California Department of Public Health (“CDPH”), the designated agent for the California Department of Health Care Services (State Medicaid Agency), and the California Department of Developmental Services through its agent, Sonoma Developmental Center (“SDC”), a Medicaid/Medi-Cal-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (“ICF/IID”), (collectively, “the Parties.”) This Agreement will be executed and implemented to further the objectives of the California State Medicaid program (“Medi-Cal”) to facilitate the delivery of quality health care and rehabilitative services to the community served by SDC and to promote consistent, sustained compliance by SDC with all applicable provisions of the federal Social Security Act (“the Act”) and regulatory Conditions of Participation (“CoPs”). Section 1905(d) of the Act of the Act, 42 U.S.C. § 1396d (d) (defining “intermediate care facility for the mentally retarded”, now “Intermediate Care Facilities for Individuals with Intellectual Disabilities or “ICFs/IID”); 42 C.F.R. Part 483, subpart I (CoPs); see also 42 C.F.R. Part 442 (provider agreement and certification of ICFs/IID).

The Agreement and attached Technical Addendum (incorporated by reference) will be executed, implemented, and applicable only to the Stoneman, Malone, Poppe, Bentley, Roadruck, Cohen units and any other certified units. This PIP does not pertain to the remaining licensed-only units at SDC. Further, this Agreement will be effective and binding on the parties beginning March 13, 2013 and will continue in effect through the date of the full Medicare/Medi-Cal certification survey referenced in Section 4 below, unless any of the following occurs earlier: (1) the Parties jointly agree in writing that the material terms of the Agreement have been fulfilled; (2) SDC voluntarily withdraws from Medi-Cal participation; (3) SDC breaches any material provision of its obligations herein; or (4) CDPH or the United States Department of Health and Human Services terminates SDC’s Medi-Cal provider agreement.

The agreement may only be amended, or extended beyond the date of the full Medicaid/Medi-Cal survey by joint and mutual written agreement of the Parties.

All timelines in this Agreement are to be measured by calendar days unless otherwise specified. If a deadline falls on a weekend or holiday, it will be extended to the next working day.

Recitals

Whereas, a CDPH ICF/IID Medicaid compliance survey of SDC completed by CDPH on July 3, 2012 found noncompliance with six (6) of the applicable CoPs, including deficiencies negatively affecting or with the potential to negatively affect the health and safety of clients;

Whereas, on July 19, 2012, CDPH issued a letter to SDC initiating the process for termination of SDC's participation in the Medi-Cal program as a provider of ICF/IID services and notifying SDC that CDPH would only conduct a follow-up survey of the ICF/IID based on SDC's submission of credible documentation of correction;

Whereas, on December 12, 2012, a CDPH follow-up survey of SDC found continued condition-level noncompliance with four (4) of the CoPs applicable to ICF/IIDs, including deficiencies that posed immediate jeopardy to client health and safety;

Whereas, on December 22, 2012, CDPH issued a notice to SDC transmitting the findings of the December 12, 2012 survey and advising the facility that based on these findings CDPH intended to terminate SDC's Medi-Cal provider agreement effective January 4, 2013 pending the results of a revisit survey;

Whereas, on January 22, 2013, CDPH issued a notice letter to SDC extending the previously established termination date to March 12, 2013 based on the revisit survey exited on January 22, 2013;

Whereas, CDPH has determined that it is in the best interest of the Medi-Cal program and ICF/IID clients in particular, and the community served by SDC generally, to allow SDC a further opportunity to achieve and maintain compliance in view of: (1) the impact that the immediate termination of SDC as a provider of ICF/IID services would have on the clients, staff and community; (2) SDC's acknowledgment of the cited violations and commitment to undertake the comprehensive action necessary to eliminate the underlying deficiencies and make sustainable improvements; and (3) the commitment by the State of California to provide the financial and human resources needed to implement the systemic changes required to achieve and maintain substantial compliance with all applicable Medi-Cal requirements and, thereby, ensure the health and safety of SDC's clients;

THEREFORE, CDPH agrees to stay the termination from the Medicaid/Medi-Cal Program for the Stoneman, Malone, Poppe, Bentley, Roadruck, Cohen units for the duration of this Agreement (subject to the conditions set forth in this agreement), and any extension thereto mutually agreed to and memorialized by the Parties, in consideration of the following commitments by SDC:

- 1) Plan of Correction (POC): Within ten (10) working days of signing this Agreement, SDC will submit to CDPH a plan for correcting all cited deficiencies as identified on the January 22, 2013 survey. The Plan of Correction must address all of the required elements, and such plan is deemed to be acceptable by CDPH.

- 2) Contract for Independent Consultative Review Experts (“ICREs”):
Within **thirty (30)** days after the effective date of this Agreement, SDC will provide CDPH with a draft contract between SDC and a third party hereinafter designated as the Independent Consultative Review Expert (“ICRE”) with expertise in the design, implementation, management and evaluation of ICF/IID services or similar complex healthcare delivery systems. The contract must set forth the composition and credentials of the ICRE team consistent with the following:

The team must include professionals with expertise in the design, implementation and management of large healthcare facilities for specialized populations as well as professionals with demonstrated national expertise in all aspects of ICF/IID services, including, but not limited to:

- (a) assurance of a safe and community oriented environment at SDC;
- (b) active treatment modalities/ programs;
- (c) leadership and management supervision and accountability;
- (d) assessment of the quality and appropriateness of services, including health services and medication and pharmacy services provided to clients in accordance with the Medicaid ICF/IID regulations;
- (e) protection and promotion of client rights;
- (f) qualified and supportive staffing resources;
- (g) and staff training, orientation, competence and education.

In addition, a component of the contract between SDC and the ICRE will include a requirement that the ICRE must include and hire a Compliance Officer. The duties of the Compliance Officer are included in Section three (3) below.

The contract shall further require the ICRE to provide assurances that no member of the ICRE currently is, or in the past 12 months has been, an employee of, or affiliated with SDC or has any other actual or apparent conflict of interest. The ICRE may engage an individual previously affiliated with SDC subject to prior approval by CDPH.

The contract must specify that the ICRE’s recommendations are to be designed to ensure compliance with all Medicaid CoPs applicable to ICFs/IID and make specific provision for the development of the Root Cause Analysis and Action Plan as described hereinafter.

The execution of the contract by SDC is subject to the express approval of CDPH, which shall not be unreasonably withheld.

Within **forty-five (45)** days of the approval of the draft contract, SDC must have an executed contract with the ICRE.

Within **forty-five (45)** days from the start date of the contract, but no later than 60 days from the execution of the contract, the ICRE will submit to CDPH a Root Cause Analysis (RCA) report. The RCA shall include, at a minimum, the following elements:

Based on previous survey deficiencies and in accordance with the Technical Addendum attached to this document, the ICRE will conduct a RCA of process and system failures and will determine and document deficiencies in care and services as well as what must be improved in order to meet the intent of system-wide correction based on the federal regulations for ICFs/IID. The report must provide details of identified obstacles and system failures that are preventing or inhibiting SDC from attaining and/or maintaining safe and acceptable standards of practice to ensure compliance with all Medicaid CoPs. The RCA will be submitted to CDPH by the ICRE, prior to issuance to SDC, and will be presented in conjunction with an oral briefing on the report's findings.

Upon receipt, CDPH, within 30 days, will review the RCA and, at CDPH's discretion, accept, reject or require SDC to direct the ICRE to revise the RCA. If CDPH accepts the RCA, it will be issued to SDC no later than two working days after the date CDPH accepts it.

Within **thirty (30)** days from approval of the RCA, the ICRE will submit an Action Plan which must address all areas detailed in the Technical Addendum attached to and incorporated in this PIP. The Action Plan must specify timeframes and measurable objectives. The Action Plan must explain how improvements will be monitored, how effectiveness will be determined and how SDC staff will determine a course change is needed.

CDPH may require the ICRE to revise the plan, at SDC's expense, before CDPH will accept the plan.

Upon receipt, CDPH, within 10 working days will review the Action Plan and, at CDPH's discretion, accept, reject or require SDC to direct the ICRE to revise the plan.

Failure by SDC to timely implement the CDPH-approved Action Plan, without good cause, as determined by CDPH, will constitute a material breach of the PIP within the meaning of the second paragraph of the preamble hereinabove.

The ICRE will submit monthly reports and updates to CDPH until the month of the full Medicaid/Medi-Cal certification survey described in section 4(b) below. Such reports and updates will detail the progression and status of SDC's implementation of the Action Plan including identification of problems that may jeopardize the successful implementation of the plan and actions underway to address those problems. Updates shall be due by the **tenth (10th)** calendar day of each month. The reports and updates will be forwarded to SDC no later than five working days after submission to CDPH. At the discretion of CDPH, these reports may be followed by face-to-face or telephone conference discussions between the ICRE and CDPH as necessary and at the expense of SDC.

- 3) Compliance Officer: The Compliance Officer will be charged with assuring that the Action Plan is followed and timelines specified therein are met. CDPH will have the authority to dialogue with any member of the ICRE including the Compliance Officer. The contractual work of the Compliance Officer shall specify that:

- a) For the duration of this agreement, the Compliance Officer will report directly to CDPH on the level of engagement of SDC's Governing Body, administrative officials, and the treatment and care by staff in a client-centered manner.
- b) The Compliance Officer is responsible for overseeing the Monthly Compliance reports for the RCA and the action plans.

The reports shall be submitted to CDPH, and concurrently to the Centers for Medicare & Medicaid Services ("CMS") Regional Office of the United States Department of Health and Human Services (USDHHS).

SDC may secure additional personal and professional services at its own discretion and expense to fulfill the terms of this Agreement.

SDC shall remain solely responsible for achieving and maintaining compliance with all applicable Medicaid CoPs and may not transfer this responsibility to any third party.

- 4) The parties further understand and agree:
 - a) Notwithstanding any provision of this Agreement, or any document generated pursuant hereto, CDPH and its agents retain full legal authority and responsibility to investigate complaints and entity reported events and otherwise evaluate compliance with applicable Medicaid/Medi-Cal requirements. To this end, CDPH and its agent may survey SDC and take enforcement action including, but not limited to, termination of SDC's Medicaid/Medi-Cal Provider Agreement pursuant to CDPH's statutory and regulatory authority.
 - b) CDPH will conduct an unannounced Medicaid/Medi-Cal certification survey of all applicable CoPs no sooner than 150 days from the date of CDPH's acceptance of the Action Plan, unless the Agreement is otherwise terminated earlier for cause.
 - c) In the event the full survey referenced in Section 4(b) herein demonstrates that SDC is in compliance with all applicable Medicaid/Medi-Cal Conditions of Participation, CDPH will promptly rescind the pending termination.
 - d) Subject to the provisions of Section 4(a), in the event that the full survey referenced in 4(b) herein demonstrates that SDC remains out of compliance with one or more Conditions of Participation, CDPH will promptly notify SDC of these findings and, based on the results of the full Medicaid/Medi-Cal survey, may initiate a termination action of the SDC from the Medicaid/Medi-Cal Program, consistent with the notice requirements at 42 C.F.R. 489.53(d).
 - e) The non-certified components of SDC (Bemis, Lathrop, Smith, and Corcoran units) will not be eligible for re-certification unless and until the Stoneman, Malone, Poppe, Bentley, Roadruck, Cohen units and any other certified units are surveyed and determined to be in compliance with all applicable Medicaid Conditions of Participation.

- 5) This Agreement shall be final and binding upon the Parties, their successors and assigns, upon execution by the undersigned, who represent and warrant that they are authorized to enter into this Agreement on behalf of the Parties hereto.
- 6) In the event SDC chooses to voluntarily cease operations, SDC shall develop a discharge plan for CDPH review no later than 10 working days from notification of voluntary closure. The relocation plan shall ensure the proper transfer of medical records and include a tracking sheet to help locate clients once they are transferred. The client discharge plan shall further provide for reasonable opportunity for clients and their responsible parties to be oriented to their treatment options and to express their preferences. The plan should emphasize that clients' rights continue through the discharge process and should encourage the involvement of clients and family members. SDC will cooperate with CDPH on client transfer efforts. Notwithstanding such plan, SDC will remain subject to all other Federal and State requirements governing the discharge and/or transfer of ICF/IID clients. Any closure shall be in compliance with 42 C.F.R. § 483.440(b) and Health and Safety Code, Division 2, Article 8.5 (§1336 et.seq.)
7. Each person executing the Agreement in a representative capacity on behalf of either party warrants that he or she is duly authorized to do so and to bind the party he or she represents to the terms and conditions of the Agreement successors and assigns, upon execution by the undersigned, who represent and warrant that they are so authorized.
8. CDPH and SDC represent that this Agreement is entered into voluntarily with knowledge of the facts described herein and upon the advice of legal counsel.
9. This Agreement contains a complete description of the bargain between the Parties. All material representations, understandings, and promises of the Parties are contained in this Agreement.
10. Terms limited to the Parties: The Agreement is not binding on CMS, USDHHS or any other component of the United States Government nor does in any way define, limit or circumscribe Federal civil or criminal authority.
11. For the purposes of this Agreement, all documents, reports and notices specified in this Agreement shall be forwarded to the following representatives:

Contact Information for California Department of Developmental Services, Sonoma
Developmental Center
Julia Lowe, Assistant Deputy Director
Program Operations
Developmental Centers Division
1600 Ninth Street, Rm 340
Sacramento, California 95814

Contact Information for California Department of Developmental Services, Sonoma
Developmental Center
Karen Faria, Executive Director
Sonoma Developmental Center
15000 Arnold Drive
Eldridge, California 95431

Contact Information for California Department of Public Health:
T. Scott Vivona, Chief of Field Operations
Licensing and Certification Program
California Department of Public Health
1615 Capitol Avenue
P.O. Box 997377, MS 3500
Sacramento, California 95899-7377

SIGNED THIS DAY BELOW:

FOR California Department of Developmental Services, Sonoma Developmental
Center:

Printed Name: Mark Hutchinson

By: ORIGINAL SIGNED BY MARK HUTCHINSON Date: 3/13/13

Mark Hutchinson, Chief Deputy Director
Department of Developmental Services
1600 Ninth Street, Rm 240
Sacramento, California 95814

FOR California Department of Public Health:

Printed Name: Debby Rogers

By: ORIGINAL SIGNED BY DEBBY ROGERS Date: 3/13/13

Debby Rogers, RN, MS, FAEN, Deputy Director
Center for Health Care Quality
California Department of Public Health
1615 Capitol Avenue
P.O. Box 997377, MS 0512
Sacramento, California 95899-7377

Technical Addendum

All milestones begin upon acceptance of the Action Plan. The approved Action Plan may modify these milestones. Actions taken by SDC prior to the approved Action Plan may fulfill SDC's responsibilities under this Addendum subject to validation by the ICRE and approval of CDPH.

Governing Body/Administration

The Sonoma Developmental Center (SDC) Governing Body failed to protect residents and failed to assure compliance with Medicaid Title 19 ICF/IID regulations CFR § 440.150- CFR §483.480.

Consistent and effective leadership is mandated through the Governing Body at CFR § 483.410 and is key to successful and sustained improvement at SDC. The Governing Body, using established performance indicators, monitors the performance indicators covering all regulatory areas affecting clients. Monitoring interventions are not currently in evidence at Sonoma and must not only be initiated, but also sustained continuously.

§ 483.410 (a) (1) states that the governing body must exercise general policy, budget, and operating direction over the facility.

§ 483.410 (a) (3) states that the governing body must appoint the administrator of the facility.

The Independent Consultative Review Experts (ICRE) in coordination with SDC staff must determine an effective management structure with processes in place designed to proactively address issues, to design and assure safe systems of care and to initiate a culture of client respect and participation in Active Treatment. In addition, the Governing Body must develop and sustain a culture of both improvement and compliance through the use of standards generally accepted in the community for quality improvement activities.

60 Day Milestone

SDC will work with the Independent Consultative Review Experts (ICRE) to develop a management and operations structure described in the Action Plan and based on the Root Cause Analysis (RCA) that assures safe and client centered services. The Governing Body is responsible to assure correction in each of the areas covered in this Addendum.

Facility Staffing

Sonoma has an inadequate number of direct and professional staff employed to ensure client health and safety and to provide active treatment services for each client. In addition, the staff

currently working with the clients is not properly trained to carry out individual training programs or to protect the clients from harm to themselves or others. Current staff members are being asked to work frequent double shifts contributing to reduced levels of alertness. Additionally, they are pulled to units frequently with minimal preparation, limited orientation to the new unit or with minimal support from supervisors or senior staff. This staffing/training deficit cascades down to create many of the dangerous and neglectful practices as observed by the survey teams.

Inadequate Numbers of Direct Care Staff:

§ 483.430 (d) (3) states that direct care staff must be provided by the facility in the following **minimum** ratios of direct care staff to clients:

- (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive or security risks, or who manifest severely hyperactive or psychotic like behavior, the staff to client ratio is 1:3.2.
- (ii) For each defined residential living unit serving moderately retarded clients the staff to client ratio is 1:4.
- (iii) For each defined residential unit serving clients who function within the range of mild retardation, the staff to client ratio is 1:6.4.

The above ratios represent the very minimum number of staff that must be present, awake, and on duty 24 hours per day, 365 days per year. The facility must determine how many direct care staff they must employ overall to maintain these ratios for each 24 hour period. This is calculated over all shifts in a 24 hour period.

30 Day Milestone

The ICRE will conduct an assessment of competent staffing needs for each defined residential living unit; identifying staffing deficits and establishing a plan to employ adequate numbers of competent staff at all levels. The analysis will consider the individual client needs in each residential living unit and what patterns (which may be above the minimum ratios) are required for each shift. The analysis will be updated every 45 days or sooner to address changes in client needs and will continue until effective staffing numbers and competence have been achieved.

60 Day Milestone

The facility will have at least 50% of the identified staffing deficits either already on board or in the orientation process. Timecards verify that minimum staffing ratios are maintained on the residential units and requests for staff to work double shifts and impromptu shifts of staff among units are decreasing.

90 Day Milestone

The facility will be fully staffed with direct care staff, identified and described in the staffing analysis, in place or in the orientation process. Time cards verify that minimum staffing ratios are maintained and requests for staff to work double shifts and impromptu shifts of staff among units are decreased by 50%.

180 Day Milestone

The ICRE will conduct a second assessment of staffing needs by residential unit to ensure that current staffing coverage continues to meet the minimum on duty staffing ratios and the needs of the clients in each unit. Any shortages are promptly addressed.

Also within the first 180 days of acceptance of the Action Plan, the facility maintains or supersedes (based upon the needs of the individual clients) minimum on duty staffing ratios in each residential living unit on a 24 hour per day basis. Double shifts and staff shifted on an impromptu basis among living units shall be in accordance with the Action Plan. The facility conducts a staffing assessment by residential unit each six (6) months to ensure that minimum on duty staffing ratios are maintained and that direct care staff are employed and trained on a continuous basis to ensure continuity of services. These assessments are communicated with the facility administration and all identified concerns are promptly addressed.

Staff Training

§484.430 (e) (1) states that the facility must provide each employee with initial and continuing training that enable the employee to perform his or her duties effectively, efficiently and competently.

By the date specified in the Action Plan, the ICRE shall conduct an assessment of the training needs of each of the staff members in every residential living unit and an evaluation of the current orientation program for every staff. This evaluation will include observations of the actual implementation of orientation of direct care staff.

By the date specified in the Action Plan, the facility will have reviewed and implemented the recommendations of the above independent assessment including a plan for the training or re-training of all the facility staff on the implementation of active treatment programs, implementation of behavioral plans and the reporting of medical situations.

By the date specified in the Action Plan, the facility will develop a comprehensive orientation program for all newly employed staff including detailed information on the active treatment

process, specific information regarding client protection and the reporting of any suspected abuse, neglect, injury of unknown origin and a preceptor component which enables the new employee to work with an experienced employee for a reasonable period of time until he/she can demonstrate competency based training on individual client Active Treatment (AT) programs.

By the date specified in the Action Plan, the facility will develop and communicate a policy that directs the frequency and process for the Qualified Mental Retardation Professional (QMRP) oversight of client active treatment program implementation, documentation, monitoring and changes in interventions and ensures staff training as indicated.

By the date specified in the Action Plan, each staff member will be trained or re-trained in the current AT programs and behavioral plan implementation for each client with whom they work. Training will include not only the methods for carrying out the programs but the communication that must routinely occur with the facility QMRP regarding the client's progress or lack of progress. Training on behavioral interventions must also include the facility policies and the appropriate manner for carrying out the components of each behavior intervention plan.

By the date specified in the Action Plan, all staff must receive training or re-training on reporting and preventing client injuries, neglect or abuse and medical observations that require the intervention of the medical staff.

All newly employed staff will complete the comprehensive orientation program and competency based trainings.

Staff Assessment

§483.430 (b) (2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

§483.430 (e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

§483.440 (c) Standard: Individual program plan. (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

- (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c) (3) of this section; and
- (ii) Designing programs that meet the client's needs.

§483.440 (c)(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

§ 483.410 Condition of participation: Governing body and management. (a) Standard: Governing body. The facility must identify an individual or individuals to constitute the governing body of the facility.

Facility must develop a mechanism to report the findings from a national patient safety survey to the Governing Body. Governing Body must act on the findings from the survey and incorporate and modify policies and procedures as necessary.

By the date specified in the Action Plan the facility will conduct a national patient safety survey to elicit feedback from staff regarding, but not limited to: whether sufficient and appropriate staff are available to provide needed services, whether staff have received sufficient training to perform their duties, whether the facility fosters an environment where staff feel they can report problems to management and the problem will be corrected, and whether staff have received timely and relevant client information to perform their duties and report findings to the Governing Body.

By the date specified in the Action Plan, the facility will resurvey staff using the national patient safety survey and report findings to the Governing Body.

Active Treatment

Sonoma has not provided a continuous pervasive, active treatment program systematic and sufficient in scope to assure that all of the clients residing in the facility are appropriately served according to the Federal regulations.

Sonoma has not provided the necessary monitoring required at various levels to ensure that active treatment is provided to each individual client residing in the facility. The day to day delivery of active treatment programs by direct care staff must be observed and continuously monitored by QMRP and interventions or revisions made promptly when indicated. The progress of the client with their Individual Program Plan (IPP) Active Treatment formal and informal programs must be closely reviewed by the QMRP and revisions made to the active treatment program plan as indicated by the documentation.

§ 483.430 (a) states that each client's active treatment programs must be integrated coordinated and monitored by a qualified individual with intellectual disabilities professional.

§483.440 (1) requires that each client in the facility receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services which are directed toward the acquisition of behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

§483.440 (d) (3) requires that each client's individualized program plan for active treatment (except those facets that must be done only by licensed staff) be implemented by all staff who work with the client including professional, paraprofessional and non-professional staff.

§483.440 (f) Standard: Program monitoring and change. (3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to—

- (i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;
- (ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and
- (iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.

By the date specified in the Action Plan, the facility working with the ICRE will analyze the current role of the QMRP in the facility, the number of QMRP currently employed/assigned to that role in the facility and their qualifications, the current case load numbers for each QMRP, the current understanding of and compliance with the responsibilities of this role by each QMRP and a projection of the number needed based on the Plan which must include a staffing plan for QMRP's.

All currently employed/assigned QMRPs will be re-trained on their responsibilities and will identify any obstacles they are experiencing in the fulfillment of their responsibilities. Sonoma management will immediately address and remove any such obstacles.

By the date specified in the Action Plan, the facility will have reviewed and implemented the recommendations of the above analysis. Additional QMRP's will be employed/assigned to reduce the number of clients that each QMRP must continuously monitor. Each newly employed/assigned QMRP will receive a comprehensive orientation to include a preceptor component.

Facility QMRPs will be actively engaged in observation and training of direct care staff across all shifts and client waking hours during implementation of formal and informal programs, communication with interdisciplinary team members when programs require changes and observation/reporting of any signs of suspected mistreatment or abuse. The QMRPs will report

any unresolved concerns to the Safety Committee and the Governing Body. Such reports are promptly investigated and addressed with written corrective actions.

By the date specified in the Action Plan, the facility will incorporate into the ongoing quality program monitoring of the implementation of formal active treatment programs and informal interactions between direct care staff and clients. Prompt actions are taken to address any concerns identified as a result of the monitoring.

Facility monitoring and analysis of the active treatment services at the facility will be an active component of the facility quality program. Facility administration takes prompt and effective action on any findings of the analysis.

By the date specified in the Action Plan, the facility will complete implementation of all recommendations of the above analysis. Clients will be receiving continuous active treatment.

Specially Constituted Committee

Within 30 days of the acceptance of the Action Plan, facility will document and provide evidence that it is actively and continuously recruiting individuals to serve on this committee. Facility efforts will include outreach to patient advocates and patient rights organizations to ensure clients active treatment and clients rights are protected and discussed in this forum. Facility will complete minutes from these meetings which will be provided to the Governing Body. Governing Body must act on the minutes from the specially constituted committee to resolve reported issues and incorporate and modify facility policies and procedures as necessary.

Client Behavior and Facility Practices

The extent of serious client injuries at Sonoma, during client-staff interactions, client-client interactions and PICA episodes, indicates that the direct care staff is not familiar with or is not following acceptable interventions to manage inappropriate client behavior.

§483.450 Individual programs and activities need to regularly include use of positive techniques, teaching strategies, and supports. Efforts must be made to reduce or eliminate the use of restrictive techniques including physical restraints with positive results.

§ 483.430 (b) (2) states that the facility must have available enough qualified and professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

30 Day Milestone:

The ICRE must conduct an analysis of all episodes of inappropriate client behaviors in each residential living unit within the last 120 days. This analysis must review antecedents, staff action or inaction in relation to facility policies or individual programs, and whether a different action on the part of the staff could have de-escalated the behavior and prevented injury or serious outcome for the client.

All such incidents occurring within the first 30 days of acceptance of the Action Plan must be immediately analyzed, reviewed and revised. The IDT will review and take action within 24 hours or the next working day.

Also, within the first 30 days of the effective date of acceptance of the Action Plan, the ICRE and facility will review and make recommendations regarding the current structure, roles, and staffing levels for psychology services within the facility. The analysis must address the ability of current staff to adequately perform the responsibilities of assessment, individual program planning, implementation, documentation, staff training and program monitoring and change.

60 Day Milestone:

The facility will have reviewed the above analysis and implemented the recommendations. Additional staff positions, identified to be needed by the analysis, will be in the recruitment process.

Also, within the first 60 days of the effective date of the Action Plan facility psychology staff will continue a review of all current behavioral intervention programs and clients without such programs who exhibit behavioral episodes. Client programs will be revised or developed as indicated by individual client needs. Direct care staff will be trained on the revised or new programs by the psychologist who authored the behavior plan.

90 Day Milestone:

Facility psychology staff will complete the review of all current behavioral intervention programs and clients without such programs who exhibit frequent behavioral episodes. Client programs will be revised or developed as indicated by the reviews. Direct care staff will be trained on the revised or new programs.

120 Day Milestone:

The facility will have additional psychology staff in place (if indicated by the results of the facility analysis). All newly employed psychology staff will have completed a comprehensive orientation program to include all applicable competency training and to include a preceptor component.

Also within the first 120 days of the effective date of the Action Plan, psychology staff will be assigned caseloads that enable them to adequately and effectively conduct individual assessments, participate on interdisciplinary teams and develop behavioral support plans, train direct care staff to implement the behavior plans, track targeted behaviors by reviewing the documentation of the type of data and frequency of data collection necessary to assess progress toward the desired objective, monitor effectiveness of the behavior plan, the implementation of plans and initiate revision to the client behavior plans as indicated.

Client Protections

The facility has failed to provide a safe environment for the clients residing at Sonoma resulting in numerous serious client injuries. The facility is responsible to organize itself in such a manner that it proactively assures that individuals are free from serious and immediate threat to their physical and psychological health and safety.

§483.420 (a) (5) states that the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

§ 483.420 Individual freedoms must not be restricted.

By locking doors and securing money, SDC has failed to allow individuals freedom of access to homes, bedrooms, outside patio areas, dining rooms and has restricted other client rights without justification.

30 Day Milestone:

The ICRE will conduct an analysis of all client rights violations including access restrictions, allegations of abuse, neglect, mistreatment, misappropriation of clients' property, individual client complaints, accidents, reports of injuries from unknown sources within the facility for the past year. This analysis will identify all instances where staff action resulted in, where staff failure to act resulted in or inadequate staff supervision resulted in the client injury. The analysis will also evaluate whether the follow-up actions taken by the facility administration were appropriate and timely and resulted in prevention of repeat or similar events and individual's being taught and encouraged to claim and exercise his/her rights.

Also, no later than 30 days after the effective date of the Action Plan and in accordance with the Action Plan, all current facility staff will receive training or re-training on the protection of clients from injury and the comprehensive reporting of possible abuse, mistreatment or neglect and individual's being taught and encouraged to claim and exercise his/her rights.

Also within the first 30 days of the effective date of the Action Plan, the facility will implement an aggressive program to promptly investigate all client mistreatment, neglect, injuries or

allegations of mistreatment or abuse. Each occurrence is promptly reported, thoroughly investigated and the appropriate administrative action taken as indicated.

Also within the first 30 days of the effective date of the Action Plan, the facility will increase the amount of time (based upon incidents of inappropriate client behavior, inexperienced staff, changes in client programs, etc.) that direct care staff supervisors and behavioral staff are present in the client residential units and day program areas. The facility will provide evidence that staff intervene promptly when indicated to prevent any mistreatment and/or injuries and individual's being taught and encouraged to claim and exercise his/her rights.

Evidence must be available to confirm that individuals are being taught and encouraged to claim and exercise his/her rights.

60 Day Milestone:

All findings of the above analysis will have been reviewed by the facility administration and governing body and appropriate follow-up action taken to address all recommendations.

Data confirms that the incidence of client injuries or allegations of mistreatment or abuse has declined in accordance with the Action Plan. Observations and interviews reveal that individuals are exercising his/her rights and individual freedoms are promoted.

120 Day – Duration of the Agreement

As a component of the quality program the facility maintains continuous monitoring of all allegations of client abuse, neglect and mistreatment and client injuries, and client rights violations, occurring at the facility and ensures that prompt and appropriate action is taken as indicated.

Facility staff receive periodic refresh training on preventing and reporting mistreatment, abuse or neglect and individuals are being taught and encouraged to claim and exercise his/her rights and individual freedoms are promoted.

Mandatory Reporting

Sonoma has not always reported incidents to appropriate regulatory and law enforcement officials that warrant investigations according to state law and regulations. The facility has failed to report incidents timely to regulatory and law enforcement agencies and have instead relied on the findings from internal Office of Protective Services or facility policies and procedures on whether to report incidents or use as the basis for corrective action.

§483.420 (d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

§483.420 (d) (3) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.

§483.420 (d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken.

30 Day Milestone

Within 30 days of the effective date of Action Plan the facility will review all policies and procedures for reporting incidents occurring within the facility and at external locations if associated with facility sponsored activities. The facility will revise any and all policies and procedures to ensure that the facility policy does not contain any criterion that would prevent reportable incidents from being communicated to regulatory and law enforcement agencies in accordance with state laws and regulations. Facility will modify its new employee orientation to include specific training on the incident reporting policy.

By the date specified in the Action Plan, facility has trained all facility employees on the new reporting policy and procedure and will present evidence of training.

HEALTH CARE SERVICES

Sonoma has not provided sufficient health care services to clients to ensure that they receive all medical preventive and treatment services as ordered by physicians or as dictated by standards of practice. The facility has failed to maintain an appropriate and safe medication administration system in compliance with Federal, State and Local Laws.

§483.460 (c) (1) requires that the facility provide clients with nursing services in accordance with their needs. These services must include participation as appropriate in the development, review and update of an individual program plan as part of the interdisciplinary team process.

§483.460 (c)(3) (iii) requires a review of the health status of those clients not requiring a medical care plan at least quarterly or more often depending on client need.

§483.460 (c) (4) requires that the clients receive other nursing care as prescribed by the physician or as identified by client need.

§483.460 (k) (2) requires that the drug administration system for the facility assures that all drugs are administered without error.

§483.460 (m) (3) requires that the facility ensure that drugs and biologicals are packaged in containers designated for a particular client.

30 Day Milestone:

The ICRE shall conduct an analysis of the quality of nursing services provided to the clients of the facility. The analysis must evaluate the quality and quantity of nursing services based upon the identified health needs (both prevention and treatment) (routine and urgent) of the clients at Sonoma; whether client health care needs are periodically assessed by the nursing staff and timely, appropriate services are provided to them based upon these assessments; what procedures are in place by the nursing staff to ensure that medications are maintained in a manner consistent with Federal, State and Local laws; what procedures are in place to ensure that medications are administered in accordance with physician orders; timeliness of nursing staff responses to requests from direct care staff for assistance; appropriateness of nursing staff responses to direct care staff requests for assistance; level of interaction by the nursing staff in the training of direct care staff in the reporting of client health care situations.

Also within the first 30 days after the acceptance of the Action Plan, the facility will assure that licensed nurses at the facility provide prompt assessment of client needs when indicated, for example when an injury occurs or an unexpected incident, such as feeding tube dislodgement occurs.

Also within 30 days of the acceptance of the Action Plan, the ICRE working with SDC will determine number, type and causes of medical related incidents and/or injuries and untoward events including events that lead to client hospitalization in the last year. This review will include incidents where health care services were requested by the ICF/IID, analysis of the timeliness of the Health Services Specialist (HSS) response, what their response was including delegation of their task and if the response was appropriate.

Review will also include evaluation of medication storage and administration system in each residential living unit. This review will include receipt of medications, storage of medications, medication security, accuracy of administration (consistent with physician orders), handling of discontinued medications, labeling of medications and documentation of administration.

Also within the first 30 days after the acceptance of the Action Plan, the facility will retrain all current nursing staff on procedures for delivery of health care assessment and health care services to the clients. In addition, facility will assure emergency assessments are conducted in a timely manner with evaluation and monitoring of effectiveness reported to the quality committee.

Also within the first 30 days after the acceptance of the Action Plan, the facility nursing staff will conduct health assessments every quarter on each client at the facility to identify any services that are required by nursing staff or direct care staff or by the client themselves. Consistent with the plans, they will communicate promptly with physicians when indicated, conduct timely and appropriate follow-up to identified client health care issues and provide direct care staff and client training as indicated.

60 Day Milestone

All medication administration system recommendations must be implemented at the 60 day Milestone.

The facility will begin implementation of all the recommendations from the analysis of nursing services at the facility. Any new nursing staff indicated by the analysis will be in the hiring process.

Nursing staff of the facility will continue to complete updated assessments on all clients at the facility.

All newly employed nursing staff will complete a comprehensive orientation including all competency training and to include a preceptor portion to allow them to learn the nuances and rhythms of the facility while being supported by another nursing staff member.

90 Day Milestone

The facility will have implemented all recommendations of the above two analyses.

Also within 90 days of the acceptance of the Action Plan, the facility will have a component within their quality program to periodically audit to ensure that the clients promptly and accurately receive all the health care services (including nursing services, physician services, pharmacy services, dental services, dietary services, and laboratory services) as needed. Quality program findings are reported to the administration and nursing services will address findings and take appropriate actions.

PHYSICAL ENVIRONMENT

Sonoma has failed to ensure that client assistive devices are maintained clean and in good repair. Infection control issues have not been identified and addressed promptly by the facility.

§483.470 (g)(2) requires that the facility maintain in good repair, and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

483.470(1) (1) required the facility to provide a sanitary environment to avoid sources of transmission of infections.

By the date specified in the Action Plan, the ICRE working with SDC will complete a survey of all clients identifying all assistive devices and evaluating the condition (integrity and cleanliness) of the devices. This includes not only mechanical devices such as walkers and specialized wheelchairs but also personal assistive devices such as eyeglasses, splints, braces and communication devices. Cleaning of all devices has been accomplished and repairs made as indicated. Referrals have been made for replacements as indicated.

By the date specified in the Action Plan, the facility will train or retrain all staff on infection control procedures in the residential living units and the day program. This training will include the environment and interactions with the clients and their belongings.

The facility will begin periodic and unannounced observations in the residential living units and the day program to ensure that infection control measures are being followed. Staff will receive additional training if any negative findings. Monitoring reports are provided to facility administration on a monthly basis and any administrative action is taken as indicted.

DIETETIC SERVICES

SDC failed to assure safe food delivery system.

CFR § 483.480(a) (1) states that each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets.

SDC failed to have client participation in the food production, serving and clean-up system. SDC has not allowed individuals dining independence that will help the individual live in a less restrictive environment. Individuals are not encouraged, permitted and reinforced for being as independent as possible during meals. Family style dining is not available to all individuals who are able to participate. Individuals have not been observed to be involved in setting their own tables, shopping and putting away their food, preparing, serving, and cleaning up after meals, as appropriate for the individual client. In addition, clients are not being encouraged to use appropriate clothing protectors during mealtimes.

SDC has failed to ensure client texture modifications were followed for physician prescribed modified diets.

CFR §483.480(d) (4) requires that individuals learn skills in accordance with their functional levels including: use of utensils, meal preparation, family style dining and ordering food in restaurants.

By the date specified in the Action Plan and based on individualized assessments and client ability, SDC must assure capable clients are involved in each step of food shopping, meal preparation and meal service as required.

By the date specified in the Action Plan, the facility will assess why physician diet orders are not followed and will develop a plan to assure that client diets are ordered, transmitted and followed by facility staff.

By the date specified in the Action Plan, the facility will have determined causes and factors related to lack of client involvement in meal service as well as failures in safe food delivery. The Action Plan will address actions to be taken to correct this to assure clients are trained and are involved in all aspects of meal service as possible. Reviewing and assuring safe food delivery must be addressed in the facility Action Plan.