United States v. State of Texas

Monitoring Team Report

Abilene State Supported Living Center

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Submitted By: Maria Laurence, MPA

Monitoring Team: Victoria Lund, Ph.D., MSN, ARNP, BC
Edwin J. Mikkelsen, MD
Antoinette Richardson, MA, JD
Susan Thibadeau, Ph.D., BCBA-D
Nancy Waglow, MS, MEd
Wayne Zwick, MD

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Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/her findings, as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 were considered baseline reviews. Compliance reviews began in July 2010, and are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of the first compliance review of Abilene State Supported Living Center (ABSSLC).

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in a section of the report for which another team member had primary responsibility. For this review of Abilene SSLC, the following Monitoring Team members had primary responsibility

for reviewing the following areas: Antoinette Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services; Wayne Zwick reviewed, medical care, dental services, and pharmacy services; Victoria Lund reviewed nursing care, restraint, and safe medication practices; Susan Thibadeau reviewed psychological care and services, restraint, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed integrated protections, services, treatments and supports, and serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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

II. **Methodology -** In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of August 2 through 6, 2010, the Monitoring Team visited Abilene State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans

(PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans (CLDPs), and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, PSP team meetings, discipline meetings, incident management meetings, and shift change.

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

III. **Organization of Report –** The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the Facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each Facility, this section will highlight, as appropriate, areas in which the Facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the Facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA and each of the chapters of the HCG, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July 2010; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, Individual #45, Individual #101, etc.). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the entire Monitoring Team would like to thank the management team, individuals served, and staff of Abilene State Supported Living Center for their willingness to share information and their time to assist the Monitoring Team in conducting its review. During the August 2010 review, as during the baseline review, ABSSLC team's willingness to provide honest assessments of the status of compliance was appreciated. In addition, when during the course of the review issues were brought to the management team, it responded by addressing them immediately, and thoughtfully. The Monitoring Team also would like to thank the State Office staff who were on-site during the review for their contributions, as well. As always, they were helpful in providing assistance and information that greatly aided the Monitoring Team.

As is illustrated throughout this report, ABSSLC had a number of good practices in place, and in a number of the areas in which there was a need for improvement, the Facility had plans in place to make needed changes. The following provides some brief highlights of some of the areas in which the Facility was doing well and others in which improvements were necessary:

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at ABSSLC:

<u>Restraints</u>

- A number of areas of progress were noted with regard to the use of restraint, including:
  - Reducing the use of chemical restraint;
  - Bringing policies into compliance with DADS policies;
  - Beginning the introduction of desensitization procedures and other strategies for individuals who resist medical and dental appointments; and
  - Trending use of restraint to allow for systemic responses to identified issues.

<u>Abuse, Neglect and Incident Management</u>

- A number of areas of progress with regard abuse, neglect, and incident management, including:
  - Policies on Abuse/Neglect and Incident Management had been adopted;
  - Some 98% of staff had been trained in abuse and neglect reporting; and
  - Investigators had been trained in Root Cause Analysis, and the Incident Management Coordinator had begun to use the process. This had begun to generate cooperative problem solving across disciplines.

<u>Quality Assurance</u>

- A Quality Enhancement Plan had been developed.

- Quality monitoring tools had been adopted, were being tested, and modifications were under development to share at the State level.
- Trend reports and analyses had begun to be provided to the units and residences.
- The Program Improvement Council was focused on the Settlement Agreement, and what needed to be done to come into compliance.
- A process for the development and implementation of Corrective Action Plans (CAPs) to address outstanding elements of the SA was underway, with first plans having been completed for most sections of the SA.

Integrated Protections, Services, Treatments and Supports

- ABSSLC had piloted a new format of the PSP. Five Qualified Mental Retardation Professionals (QMRPs) had been working with the pilot versions of the new PSP, sharing challenges, offering suggestions for improvements, and generating Personal Support Plans (PSPs) in a new way. Staff who had been involved in the pilot project were excited about the expansion of participation of individuals, families, and direct support professionals. They reported that the revised process helped to identify what individuals preferred, and what their goals were, and then assessment information was used to assist the team in developing a plan that was more person-centered. The process reportedly focused more on individuals' strengths, and built support and service configurations around the person to support him/her in achieving desired goals.

Psychiatric Care and Services

- The Facility had made considerable progress toward meeting the provisions of the Settlement Agreement related to the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) side effect monitoring, as well as the administration of the Reiss screening instrument.
- Drug regimen reviews performed by the Pharm. D. provided valuable feedback to both the Primary Care Physician and the Attending Psychiatrists. Systems should be implemented to ensure that these documents are reviewed by the appropriate physician and responded to in a timely manner.

Psychological Care and Services

- Although the Facility had not been able to recruit additional Board Certified Behavior Analysts, there had been a significant increase in the number of staff pursuing this credential. Also of note was the increased training in Applied Behavior Analysis provided to psychology staff by both Facility personnel and external consultants.
- Improvements had been made to the peer review process, with changes in staffing and format of the Facility's Behavior Support Committee, and the hiring of external consultants.
- Data systems had been improved in an effort to ensure more accurate measurement of identified problem behaviors.
- Guidelines for the completion of Structural and Functional Assessments had been developed and implementation had begun.

Medical Care

- There had been attentiveness to such areas as the annual history and physical examination, as well as administration of vaccinations. There also appeared to be good up-to-date treatment of acute care illness.

Nursing Care

- The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and the frequency of the medication observations for nurses was changed from annually to quarterly. Also, the Medical Director and Pharmacy staff now were involved in the Medication Error Committee. This collaboration should produce valuable assessments and corrective actions regarding the medication administration system.

Pharmacy Services and Safe Medication Practices

- With regard to the provision of adequate pharmacy services, and safe medication practices, there had been substantial progress since the last team visit. Specifically:
  - Primary care practitioners were responding formally to the Quarterly Drug Regimen Review (QDRR);
  - Adverse Drug Reactions (ADRs) were being reported; and
  - Drug Utilization Evaluations (DUEs) were being completed.

Dental Services

- The Dental Department had completed documentation of the annual exams and any acute care exams, and it provided a full scope of dental services, with emphasis on oral hygiene.
- The Dental Department had made all information available through the medical record, and all notations were in the integrated progress notes, so the PST had the latest information available.
- The addition of a dental hygienist had allowed for the development of an oral health program with selected individuals.

Communication

- Generic communication devices were available in many locations on campus. Unfortunately, individuals and staff did not access these to support functional communication. The Facility should consider identifying a home to pilot the development and implementation of functional communication systems across all environments. This would promote interdisciplinary planning, development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.

Habilitation, Training, Education, and Skill Acquisition Programs

- The QMRP Coordinator had begun working with staff from the psychology department, particularly the Behavior Analyst, to ensure that training objectives reflected all necessary components. Further collaboration between these two departments was apparent in the draft outline of a new training program for staff in the area of teaching individuals with disabilities.
- The QMRP Coordinator also reported that he was working closely with the Active Treatment Coordinator to improve overall engagement of the individuals served.

Most Integrated Setting

- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed.
- The post-move monitoring identified some issues with regard to the provision of services at the community sites, and these items appeared to be addressed appropriately with provider agencies.

Consent

- As reported previously, ABSSLC had taken some steps to identify potential guardians for individuals who needed them. The Guardianship Committee had discussed the process of matching individuals who needed guardians with the people interested in becoming guardians. Appropriately, the Committee agreed that it was important for there to be a process to allow the potential guardians to meet and become acquainted with individuals determined to need guardians. A process was discussed whereby they would be assigned to the less formal role as the individual's advocate. After a period of time, a decision would be made regarding whether the two were appropriately matched with one another. This would seem to be a reasonable and appropriate step, given the implications of pursuing formal guardianship.

Recordkeeping and General Plan Implementation

- Significant progress had been made in converting the active records to the new Table of Contents required by the State Office. At the time of the review, 450 out of 452 records (99%) had been converted. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Clerks assigned to the Units. The next step was developing Individual Notebooks for each individual.
- Since the baseline review, a new policy had been put in place in July 2010 requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements.
- Progress had been made with regard to the auditing of records. At the time of the baseline review, no auditing was being completed. At the time of this review, both the records department and the QE Department had begun conducting record reviews.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at ABSSLC:

Restraints

- Areas with regard to restraint in which additional work needed to be done, included:
  - Gaining the cooperation of staff in following the procedures for use of restraint and accurate documentation of restraints;

- Improving the response times of Restraint Monitors to within the policy guidelines;
- Improving the descriptions on Restraint Checklists to allow an understanding of what transpired prior to the use of restraint; and
- Training and monitoring staff performance when assigned to supervise someone in restraint so that they understand the importance of having "eyes on" the individual, so that he/she will not be injured.
- Adequately assessing individuals, and revising plans as appropriate, when individuals are subject to more than three restraints in 30 days.

Abuse, Neglect and Incident Management

- Posters providing information to individuals on their rights needed to be posted in residences and other campus buildings, and staff need to be trained on why they are important.
- The timeliness of the start of investigations, as well as the submission of the final reports continued to need improvement.
- The thoroughness of the Facility's death investigations/reviews needed to be improved substantially.
- The thoroughness of the follow-up with regard to unusual incident investigations, particularly death investigations needed to be improved. Failures to do so placed individuals, as well as staff at risk.

Quality Assurance

- Quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, some modifications had been made to these tools, and they were being field-tested. It was positive that the Facility was making use of the tools developed by the Monitoring Teams. However, while on site, the Monitoring Team discussed with Facility staff some of the additional modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to:
  - The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to:
    - Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and
    - Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts.
  - The items on the tools have not been weighted, but would need to be if they were going to be used to generate cumulative scores.
  - Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific

expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators.
    - At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process.
- Trending of some basic quality indicators was being conducted. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by ABSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system.
- The next step will need to be responding to the identified trends with analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends.

<u>Integrated Protections, Services, Treatments and Supports</u>

- As is noted in many sections of this reports, comprehensive, thorough and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, Structured Functional Assessments, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning.
- Even with the newly formatted plans, not all plans such as behavior support plans, physical and nutritional management plans, nursing plans, etc. were fully integrated into the plans.

<u>Integrated Clinical Services</u>

- There had been progress made in developing integrated clinical services, especially with the psychiatric consultants and the Primary Care Practitioners (PCPs), as well as the important step of providing a nurse liaison to the hospital. However, there was a significant need to look globally at the requirements in this section of the SA. One important step would be to develop a daily morning meeting to review all significant health care concerns from the prior 24 hours (72 hours for a Monday meeting).
- The NMT was composed of staff with full-time duties in their own departments. As required by the Settlement Agreement, the creation of a Physical and Nutritional Management Team (PNMT) that is dedicated to dysphagia and dining concerns is essential at ABSSLC, as 60 percent of deaths in the recent months had been caused by or

associated with pulmonary problems. One of their important roles would be training and teaching all departments about dysphagia.

Minimum Common Elements of Clinical Care

- Documentation of annual reviews appeared to be adequate, as well the quality of acute medical care when an illness developed. However, the work-up of the illness in order to ensure it did not recur was sporadic or nonexistent in certain cases. The Medical Department needs to be proactive rather than reactive when treating illness. Rather than spending the majority of their time focused on acute illness needs, there should be a realignment of the department's goals to focus on how to prevent acute illness from occurring.
- The Facility did not have a set of medical policies or clinical pathways. Standardization of care through clinical pathways would allow measurement of quality care, and would help to assure all individuals were treated according to these guidelines. The clinical pathways, when written with sufficient detail and guidance, also could be used as a source of clinical indicators and tools by which to measure quality improvement in the medical department, and quality of health for the individual.

At-Risk Individuals

- At the time of the review, there were many risk assessment tools being used, but they had not been validated. Personal Support Teams (PSTs) were attempting to determine a risk level, but this varied widely across the campus. There was considerable energy and time being spent on risk level assessment, but it was not resulting in accurate assignment of risk levels. In addition, this time expenditure was resulting in teams not planning and implementing plans to reduce risk that had been identified.

Psychiatric Care and Services

- Psychiatric staffing at the Facility was insufficient to meet the needs of the individuals served. ABSSLC employed two part-time psychiatrists to provide psychiatric services to the 225 individuals who are prescribed psychotropic medications.
- The analysis of the medical records of individuals served by ABSSLC identified three fundamental problems, including: 1) the identification of the specific symptoms that support the psychiatric diagnosis was absent; 2) in several records, the behaviors that were described as "targets" of the psychotropic medication were also referred to in the Behavior Plan and Functional Analysis as being present on a learned-operant basis and/or a response to environmental factors; and 3) there was a lack of documentation to confirm that the psychotropic medication had been useful in reducing the frequency and severity of the behaviors they were prescribed to address.

Psychological Care and Services

- Systems for inter-observer agreement had yet to be developed, but the plan was to address this as staff became familiar with the new data collection forms.

- Behavior Support Plans and accompanying Safety Plans remained a work in progress. There continued to be a need for greater emphasis being placed on the teaching of replacement behaviors, particularly functional communication skills, expanded antecedent strategies, and enriched reinforcement strategies.
- Ensuring treatment integrity and staff competency were areas that needed continued improvement.

Medical Care

- The Medical Department had been hampered by a lack of a full complement of primary care practitioner (PCPs). As noted above, there had been attentiveness to such areas as the annual history and physical examination, as well as administration of vaccinations. There also appeared to be good up-to-date treatment of acute care illness. However what was most lacking was the aggressive diagnostic work-up and treatment to prevent repeat occurrences of such problems as aspiration pneumonia, Gastroesophageal Reflux Disease (GERD), frequent vomiting, chronic constipation, etc. Clinical pathways were needed for dysphagia, GERD, aspiration pneumonia, pica, chronic constipation, fracture prevention, repeated vomiting, weight loss, etc.
- At the time of the review, current DNR orders needed to be reviewed by the PCP and Personal Support Team (PST) to determine if they remained appropriate, if the qualifying condition needed revision in order for the Do Not Resuscitate (DNR) to remain, or whether the DNR no longer applied and should be rescinded.
- The mortality review process needed to occur in a more timely manner, and may best be conducted by a two-tier approach, a short medically focused review, and a later lengthy interdisciplinary review.
- Moreover, mortality reviews have the ability to be highly educational with many recommendations, often with one or more of such recommendations for each department on campus. Yet, the ABSSLC Clinical Mortality Review Committee repeatedly had no recommendations. There may be some concern that there is increased liability or discoverability when reviewing such cases. If so, it is unfortunate that this has had such a negative impact on mortality review system at ABSSLC. Individuals' lives would be improved if the process allowed for critical review, and lessons learned could be applied to others.

Nursing Care

- There continued to be a number of significant issues regarding the completeness and adequacy of nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a status change, and of assessments prior to the transfer to an off-site medical center as well as upon return to the Facility.
- There were significant problems found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, the State Office had modified the Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. Competency-based training had not yet been initiated for these areas.

Pharmacy Services and Safe Medication Practices

- A method to monitor the use of "stat" medications had not been resolved. This may require several department directors to convene to determine the roadblocks, and to create a system in which the clinical pharmacist can be helpful at the time of the need for medication.
- There were a number of problems remaining to be resolved with regard to the periodic completion of the evaluations to monitor the presence of side effects, such as tardive dyskinesia.
- Medication errors and variance remained a concern. Accuracy in reporting still appeared to be a concern, as well as the adequate identification of trends, and follow-up activities to address issues identified.

Physical and Nutritional Supports

- As was discussed by the Monitoring Team with members of ABSSLC's management team, at the time of the review, the Physical and Nutritional Management Team (PNMT) was not fulfilling its responsibilities, and as a result, individuals were at risk. The PNMT should have but was not identifying the individuals with the most complex health, physical and nutritional support needs, and completing a comprehensive assessment, leading to the development of individual-specific strategies to minimize their identified high risk health concerns. The PNMT also should have been responsible for determining not only the efficacy of the individual-specific outcomes, but providing analysis on a systems level to develop and monitor thresholds/triggers for integration into the Facility Risk Management and Quality Improvement Systems.
- Given the large caseloads and other responsibilities of the therapists assigned to the PNMT (NMT), it made it virtually impossible to implement a PNMT per the requirements of the SA.
- A review of individuals who had died within the time period of July 2009 to June 2010 identified 10 of the 24 individuals' causes of death as respiratory failure, pneumonitis due to inhalation of food or vomitus, acute respiratory failure, and pneumonia. An extensive, critical review of the mortality reports, including recommendations, by the PNM Team would be an important learning strategy to identify future person-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs but, most importantly, for individuals at the highest health risk levels

Physical and Occupational Therapy

- None of the OT/PT evaluations and Eating Evaluations/Nutritional Management Plans reviewed contained recommendations for formal OT supports/services with the exception of dining plan recommendations. The large caseloads of Occupational Therapists, and the responsibility of completing evaluations appeared not to leave additional time to provide direct therapy.

Dental Services

- The number of chemical and mechanical /physical restraints remained high. There needs to be a goal with a related action plan to diminish the numbers of restraints used. Desensitization plans or other strategies to reduce the need for restraint were not available to the majority of individuals who would benefit from such programs.

Communication

- At the time of the review, the caseloads for speech language pathologists and speech assistants would not allow therapists to be active members of the individual's PST, or provide adequate functional communication supports.
- It appeared that a number of individuals who did not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they had not been assessed, and/or plans developed to meet their needs due to inadequate staffing levels. Even for individuals for whom recommendations had been made regarding communication, these were not integrated throughout their PSPs to make communication a functional part of their 24-hour day.
- There was a lack of collaboration between the psychology and speech/communication departments. As a result, concerns were raised regarding communication techniques that were either missing from PBSPs, or ones that might have been counterproductive.

Habilitation, Training, Education, and Skill Acquisition Programs

- Assessment of individuals' needs remained incomplete. While the Positive Assessment of Living Skills (PALS) had been introduced, only portions of this tool were used to assess current skill levels. This resulted in plans that were limited in scope.
- There had been some improvements noted in the Personal Support Plan documents, however, Training Documentation Reports continued to lack the information and degree of specificity needed to ensure effective teaching and resulting skill development.
- Activities provided in homes, treatment centers, and workshop areas continued to be very limited, often resulting in poor levels of engagement by the individuals served. Lastly, insufficient training was provided in more integrated, community-based settings

Most Integrated Setting

- At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations.
- Since the baseline review, when no obstacles to individuals' movement to the most integrated setting were identified in PSPs, improvements had occurred in that the newer plans included obstacles and plans to overcome them. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs.

- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.

Consent

- Some of the concerns related to the current process included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague and did not appear to be based on specific assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. It is hoped that these issues will be resolved when the State issues its policy on guardianship, and it is implemented by the Facility.

Recordkeeping and General Plan Implementation

- As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development.
- No action plans had been developed yet to address issues related to records. Less formally, steps had been taken to address legibility issues that had been identified in records. Some of the steps that had been taken included providing physicians with dictation machines, and obtaining name stamps for many clinical staff that allowed them to stamp their name and then sign above the stamp.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #001: Use of Restraint, dated 8/31/09; o ABSSLC Policy: Use of Restraint, dated 6/10; o ABSSLC Plan of Improvement (POI), dated 5/17/10; o ABSSLC Supplemental Plan of Improvement, dated 5/17/10; o ABSSLC Fiscal Year (FY) 10 Restraints Trend Analysis from 6/1/10 to 6/30/10; o Texas Department of Mental Health/Mental Retardation (MHMR) – ABS: Restraint by Facility: 1/1/10 to 6/30/10; o ABSSLC Trend Analysis Report FY10 for Quarter 3 (March to May 2010); o Minutes of Incident Management Review Team Meeting, dated 7/13/10; o Minutes of Incident Management Review Team Meeting, dated 1/1/10 through 6/30/10 and 7/13/10; o Restraint Checklist, revised 12/09/08; o List of Individuals Restrained from 1/1/10 through 7/1/10; o Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint 11/24/08; o Restraint Reduction Plan Minutes, dated 5/26/10; o Efforts to Reduce the Need for Medical/Dental Restraints; o When Do Teams Need to Utilize Desensitization Programs (handout); o Desensitization Plans for: Individual #242, Individual #252, and Individual #491; o Request for Medical Clearance for Individual #146, dated 3/4/10; o Unusual Incident Report for Individual #79, dated 7/21/10; o Psychological Assessment for Individual #79, dated 7/26/10; o List of Approved Restraint Coordinators; o Chemical Restraint – Behavior, FY10; o Chemical Restraint Trending; o Section C Presentation provided by Catherine Hennington; o Injuries During Restraint from TX-AB-1008.II.9; o Restraint documentation for the following individuals: Individual #313, Individual #310, Individual #486, Individual #234, Individual #260, Individual #324, Individual #146, Individual #304, Individual #387, Individual #199, Individual #163, Individual #540, Individual #43, Individual #438, Individual #81, and Individual #293; o Restraint Records for: Individual #387 on 5/25/10; Individual #199 on 5/20/10; Individual #43 on 5/23/10; Individual #530 on 6/2/10; Individual #438 on 2/11/10; Individual #93 on 4/18/10; Individual #81 on 3/23 and 4/6/10; Individual #505 on 3/1, 3/16 (two times), 3/30/10 (eight times) and 6/25/10; Individual #293 on 5/25/10; Individual #313 on 6/27 and 6/29/10; Individual #310 on 5/26 (two times), 6/1, 6/10,

	and 6/25/10; Individual #486 on 6/18 (two times), Individual #260 on 5/10/10; Individual #312 on 6/8/10; Individual #324 on 6/24/10 (two times); Individual #146 on 6/21/10; Individual #304 on 6/24/10; Individual #443 on 6/25/10; Individual #540 on 6/22/10; and Individual #399 on 6/20/10; o Behavior Support Plans for: Individual #43, Individual #438, Individual #81, Individual #505, Individual #313, Individual #310, Individual #486, and Individual #324; o Structural and Functional Assessment Reports for: Individual #505 and Individual #486; o Safety Plans for: Individual #505, Individual #310, and Individual #486; and o Addenda to Behavior Support Plans and/or Personal Support Plans for: Individual #43, Individual #438, Individual #81, Individual #505, Individual #313, Individual #310, and Individual #324 ▪ **Interviews with**: o Cathy Hennington, Director of Psychology; o Ron Manns, BCBA; o Juan Herrera, QMRP Coordinator; o Jolene Willis, Assistant Facility Director; o Direct Support Staff Member, on 8/6/10; and o Various staff during tours of Facility ▪ **Observations of**: o Living Units: 6700, 6460, 6450, 6300, 6350, and 5961; and o Weekly Personal Support Team Meeting, on 8/4/10
	Facility Self-Assessment: ABSSLC's Plan of Improvement identified the provisions of the Settlement Agreement related to restraint, subsections of those provisions and elements within subsections. The Facility rated its compliance status with regard to each subsection and element. The POI indicated that corrective action plans would be developed for any deficiencies noted with the qualification that corrective action plans were just beginning to be developed and were not scheduled to be fully implemented until December 2010. The POI for section C included a supplement addressing recommendations made in the last monitoring report. Where the POI self-assessed a section or portion of a section to be substantially compliant, it is noted in the assessment of status that follows and is compared to the Monitoring Team's findings. Quality Enhancement tools for monitoring compliance with Section C of the Settlement Agreement had been adopted and were in limited use as Program Compliance Monitors began field-testing them. ABSSLC had assigned staff to be responsible for implementing each section of the SA and of the respective POI section. The plan was for staff implementing each section to conduct a self-assessment using the monitoring tools. The results of the use of the monitoring tools by the Program Compliance Monitors would be compared to those of the self-assessments of program staff as a means of testing the reliability of the tools.
	Summary of Monitor's Assessment: ABSSLC had not achieved substantial compliance with this section of the SA, however, progress had been made in:

	▪ Reducing the use of chemical restraint; ▪ Bringing policies into compliance with DADS policies; ▪ Beginning the introduction of desensitization procedures and other strategies for individuals who resist medical and dental appointments; and ▪ Trending use of restraint to allow for identification of systemic issues. Further progress needed to be made in: ▪ Gaining the cooperation of staff in following the procedures for the accurate documentation of restraints; ▪ Improving the response times of Restraint Monitors to within the policy guidelines; ▪ Improving the descriptions on Restraint Checklists to allow an understanding of what transpired prior to the use of restraint; ▪ Training and monitoring staff performance when assigned to supervise someone in restraint so that they understand the importance of having "eyes on" the individual, so that he/she will not be injured; and ▪ Adequately assessing individuals, and revising plans as appropriate, when individuals are subject to more than three restraints in 30 days.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	ABSSLC Restraint Policy, June 2010 prohibited prone restraint at #23 in the definition section, and at Section II.C. The policy prohibited use of restraint for the convenience of staff or as a substitute for treatment. The policy at II.B. required use of less restrictive alternatives before resorting to restraint and listed options. According to the POI, ABSSLC was in substantial compliance with the requirement to prohibit use of prone restraint, but not in substantial compliance with the remainder of this provision. A sample of 39 Restraint Checklists and Face-to-Face/Debriefing forms, selected from among individuals with high restraint usage and with medical and chemical restraints, was reviewed. None of the reports reviewed indicated the use of prone restraint. The Director of Psychology and her staff were clear that if a person fell into a prone position while being restrained, the appropriate response would be to immediately roll the person to a side-lying position. If the roll to side could not be made, the appropriate response would be to immediately release the hold. In interview with the Director of Psychology, she could not recall any incidents of prone restraint or possible use of prone restraint. ABSSLC is in substantial compliance with this element of the provision. Generally, there were no indications in the materials reviewed related to restraint or in interviews that staff used restraint for convenience or punishment. The Restraint Checklist included provisions for recording whether the individual posed a serious risk of	Noncompliance

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		harm to him/herself or others. In the sample of restraint records reviewed, 31 of the 39 forms (79%) reported the restraint was due to a crisis intervention. One form did not include a designation, but based on the description it was a crisis intervention. Seven forms indicated the restraint use was for medical reasons. Of those seven, four were based on a doctor's order to prevent further injury, for example: Individual #293 who had to be restrained for suturing after a fall, or Individual # 399 who had to wear wristlets to avoid removing a catheter. The remaining three were restrained as part of a scheduled medical appointment. The Restraint Checklist provided checkboxes for common, less restrictive measures and space to comment on use of less restrictive measures prior to using restraint. The use of a checklist made it difficult to determine if individualized approaches as outlined in individuals' Positive Behavior Support Plans had been implemented. In the sample of 39 forms, 33 recorded uses of less restrictive measures, five recorded nothing because the restraint was for a medical purpose and for one (Individual #505 on 6/25) the entry was incomplete. In that situation, Individual #505 was already in a wrist-to-waist restraint with 2:1 supervision and managed to thrash about sufficiently to hit his head on an unknown object. The further restraint requested was a chemical restraint, which was granted. Of the 33 forms that provided information about less restrictive measures, three (two concerning Individual # 324 on 6/24/10, and Individual #310 on 5/26/10) used the additional space to provide comprehensive explanations of what transpired prior to the decision to initiate restraint. In addition, as discussed below, with regard to Section K of the Settlement Agreement, issues continued to exist with regard to behavioral supports provided to individuals. This is a key component to ensuring that restraint is not used in the absence of adequate behavioral supports.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	In the sample of 39 restraint records, the amount of time the individual was in restraint varied from one minute to 56 minutes for crisis intervention, and up to 13 hours (Individual #399 on 6/20/10) for those in medical restraints. The trend report for June 2010 (Individuals restrained for emergency or programmatic reasons) showed Individual #530 to have been in a personal horizontal restraint for 39 minutes. Four individuals had been in restraint for 10 to 15 minutes, and the remaining 16 restraints were under 10 minutes. This suggested that individuals generally were not being restrained for long periods of time. The Restraint Checklist required entry of a time and code for when an individual was released from restraint. There were two lists of codes: event codes (numeric) and action/release codes (letter). Sixteen of the forms in the sample had "J" entered or "Met BSP/Safety Plan definition of calm and was released." The standard for release per the	Noncompliance

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		Settlement Agreement is when the individual is no longer a danger to him/herself or others, not when calm. Four forms in the sample (Individual # 530 on 6/2/10, Individual #93 on 4/18/10, Individual # 313 on 6/27/10, and Individual # 313 on 6/29/10) had the code "L" meaning released immediately when not a danger to him/herself or others. One form for Individual #387 on 5/25/10 did not have a release code at all. The form contained the code "M" for release attempted. The situation involved aggression and self-injurious behavior (SIB) while riding the bus. As a result the restraint monitor was not present when the event occurred at 8:20 a.m., and did not review the event until 4 p.m. when the individual returned home. The Face-to-Face form was dated 5/26/10 making it unclear when the debriefing happened. On another form for Individual #81 on 3/23/10, the individual was described as having thrown soda, and a book at staff. The precipitating event was refusal by Individual #81 to return a staff member's personal cell phone when requested. This led to a basket hold and side-lying restraint. The release code was "I", released due to injury or physical distress. The restraint monitor did not arrive until after the restraint was stopped. However, she did note that the restraint was applied correctly and that staff needed retraining in the use of personal cell phones. According to the Director of Psychology, a new restraint form was under development, which would clarify the use of codes for release. It is recommended that retraining of staff accompany release of that form with an emphasis on the importance of making correct form entries. For substantial compliance to be achieved, individuals need to be released from restraint when they are no longer a danger to themselves or others, and to provide accurate documentation of this the coding on Restraint forms likely needs to be revised. In addition, it appears that staff need additional training on the use of the form and the importance of making correct entries, and restraint monitors need to arrive promptly and carefully review the checklist before approving it. The Facility's self-assessment with regard to not being in compliance with this provision was consistent with the Monitoring Team's finding.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such	ABSSLC Restraint Policy, dated June 2010 covered approved mechanical restraints at II.E. 2, and included helmets, mittens, boxing gloves and wrist-to-waist restraint. The policy at II.E.6 emphasized that mechanical and all forms of restraint "…cannot be used until less restrictive measures have been determined to be ineffective or not feasible." In the sample of 39 restraint records, the restraints used were all approved restraints. However, it was not clear that all restraints used were the least restrictive intervention necessary. Thirteen of the restraints were basket holds or side-lying restraints, the highest level of physical intervention. While there were some descriptions of attempted	Noncompliance

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	approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	interventions, without good explanations of what preceded the behavior, it was difficult to identify whether adequate steps had been taken to address the behavior before the basket hold or side lying restraint was applied to allow a determination to be made that the procedures were the least restrictive. For example: ▪ With regard a restraint involving Individual #93 on 4/18/10, it was reported on the Restraint Checklist that she was "being aggressive toward staff due to wanting to shower. Staff tried to explain she showered in the morning." Aggression toward staff was the reason for the restraint, and the restraint was specified in the BSP/Safety Plan. However, the checklist of interventions did not include the interventions in the BSP. With no indication of the severity of the aggression or whether all interventions in the BSP/Safety Plan had been attempted, it was difficult to ascertain whether the basket hold restraint was the least restrictive. ▪ With regard to a restraint involving Individual #313 on 6/27/10, it was described as "displaying SIB, …biting her finger and hands and displaying aggression toward staff, hitting staff with hanger, slapping staff in the face and kicking in the leg." This was descriptive of her behavior, but offered no indication as to what led to the behavior. Several interventions were described, and there was an indication that the restraints (basket hold and horizontal side-lying) were specified in the BSP/Safety Plan. However, the interventions did not include the interventions specified in the BSP/Safety Plan. The schedule for new employee pre-service training included positive behavior support and Prevention and Management of Aggressive Behavior (PMAB) training. The policy on the use of restraints, dated 6/10, required competency-based training of staff who may be involved in applying restraints. Specifically the policy stated, "… the trained person to meet specified standards or performance as validated through that person's demonstration that he or she can use such knowledge or skills effectively in the circumstances for which they are required (p. 2)." A review of the PMAB training materials indicated the training was intended to be competency-based and to emphasize positive intervention to avoid restraint. The trainee must demonstrate competency in the use of techniques in a test environment to successfully complete the classes. It is recommended that the Facility develop a plan to ensure demonstration of competence on-the-job. As psychology staff develop plans for assessment of treatment integrity in the application of behavior support plans, they will be able to simultaneously assess staff competence in the application of restraint. The policy appeared to be in substantial compliance with the Settlement Agreement. The sampling of the restraint records revealed that more work was needed to assure that all restraints were the least restrictive intervention, and that staff demonstrated competence with regard to the application of restraint.	

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C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	ABSSLC Restraint Policy at Section II.C.1-3. limited restraint use to only such time as "when an individual exhibits behavior in an immediate safety situation that places the individual or others at serious threat of violence or injury if no intervention occurs...," and "only when alternative, less restrictive measures have been tried and failed." Under the Restraint Policy, Safety Plans were defined as components of the PSP that may include the use of restraints along with the type of restraint, the designated situation for use, duration, and criteria for terminating the restraint. The purpose of the Safety Plan was to provide instructions for staff on preventing harm and injury during a behavioral crisis. Safety Plans were not considered to be therapeutic. During an interview, the Director of Psychology indicated that Safety Plans that were incorporated into Behavior Support Plans were being separated to avoid confusion. ABSSLC had a Restraint Reduction Committee with a stated goal of a "restraint free" campus by 2012. During the last review, a rise in chemical restraint and a reduction in physical restraint were noted. During this most recent on-site review, according to the FY10 Restraints Trend Analysis from 6/1/10 to 6/30/10, the use of physical/mechanical restraints was down for the third quarter of FY10 as compared to the third quarter of FY09, from 161 to 99 uses. The use of chemical restraint was down from 126 uses in the third quarter of FY09 to 20 uses in the third quarter of FY10. A review of the minutes from the Restraint Reduction Plan, dated 5/26/10, suggested an overall reduction in the use of restraints. Additionally, the psychology staff had begun to develop Safety Plans (as is discussed below in greater detail with regard to Section K.11 of the SA) for all individuals whose plans included restraint or those who were exposed to restraint on a frequent basis. During the meeting of 5/26/10, caution was advised as the use of programmatic restraints increased in April. The restraint data showed a steady decline from 77 programmatic restraints in September 2009 to 18 in March 2010, and then jumped to 58 in April 2010, and dropped back to 18 in May. However, there was no indication that further discussion followed regarding the cause for this increase, or the corresponding action taken to reverse this anomaly. In an interview with the Director of Psychology, she indicated that work on strategies to minimize or eliminate the need for restraint for routine medical practices began in May 2010 and were being phased in as PSPs were renewed annually. As is discussed below with regard to Sections J.4 regarding pre- treatment sedation, and Q.2 regarding dental care, it was confirmed by record review that the Facility was at the very initial stages of developing strategies to minimize or eliminate the need for physical restraint and pre-treatment sedation used with some individuals for routine medical and dental care. However, the Facility is to be commended for their efforts to reduce restraint for medical reasons. Two Board Certified Behavior Analysts had been hired to provide external peer	Noncompliance

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		review. One component of this review was the development of desensitization programs for Individual #242, Individual #252, and Individual #491. Staff are encouraged to begin consistent implementation of these plans. The Monitors agree with the Facility's POI that this subsection was not in substantial compliance in that: ▪ In one out of 39 forms (3%), "behavior crisis" was not checked, although the description of the event indicated it was a crisis. ▪ It was unclear, as described with regard to Section C.3 of the SA, if all restraints that were employed were in response to a crisis that could only be addressed using restraint. As illustrated in the examples above, it was not consistently clear that all least restrictive alternatives had been exhausted before restraint was used. ▪ In two out of two forms (Individual # 304 on 6/24/10 and Individual # 540 on 6/22/10) where chemical restraint was used to facilitate a medical appointment, there was no indication of a desensitization plan. ▪ While including desensitization plans in PSPs is underway, it is not complete according to the POI, and based interview with Director of Psychology, as well as record review.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical	ABSSLC Restraint Policy, June 2010 at II.G.1 required documentation of a face-to-face assessment of the individual within 15 minutes of application. Of the 39 restraint episodes in the sample seven were restraints for medical appointments, healing or other medical purposes and a face-to-face assessment was not required. Of the remaining 32, the face-to-face assessment was completed and on file for 28 (88%). Of the four remaining: one was incomplete (Individual #505 on 3/16/10 at 7:38 a.m.), and three were not available (Individual #505 on 3/16/20 at 3:14 p.m. and Individual # 310 on 5/26/10 at 10:45 a.m.). A licensed health care professional, usually a nurse, was not always present within 30 minutes of the application of restraint. In restraints involving Individual #310 on 6/24/10 at 10:14 a.m., on 6/25/10 at 1:12 p.m., and on 6/10/10 at 11:55 a.m., the nurse did not make the first observation until 50 to 55 minutes after initiation of each of these restraints. In restraints involving Individual #505 on 3/1/10, 3/16/10, and 3/30/10, the nurse did not make the first observation until 50 to 100 minutes after initiation of each of these restraints. For a restraint involving Individual #530 on 6/2/10, the first observation was made 55 minutes after initiation of the restraint. Individual #81 did not see the nurse for 95 minutes after restraint began on 4/6/10. Individual #324 did not see the nurse for 71 minutes after the start of restraint on 6/24/10. Of the 32 episodes of restraint in the sample that required face-to-face assessment, in at least nine (28%), the	Noncompliance

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	justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	nurse was not present until more than 30 minutes after initiation of the restraint. In the remaining 23 instances (72%), documentation showed that a nurse had been present to assess the individual. There were seven episodes where the mental status section and/or respirations were marked as "refused" by the nurse. These areas do not require the individual's cooperation to be able to make observations and document these in the appropriate section. As a result of the deficiencies noted, the Monitoring Team concurs with the Facility's POI that this provision of the Settlement Agreement was not in substantial compliance.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	Facility policy required checking for restraint-related injury at Section II.C.11, and provided for release as required by this section of the Settlement Agreement. In the sample of 39 restraint records: ▪ Nine individuals were chemically restrained and time in restraint could not be determined due to the nature of chemical restraint; ▪ Sixteen individuals were in restraint for less than 15 minutes; ▪ Four were in restraint for 16 to 20 minutes; ▪ Seven were restrained for 20 to 60 minutes; ▪ Two were restrained for over one hour; and ▪ One was restrained for an undetermined time. Of the 30 non-chemical restraints, 20 (67 %) were 20 minutes or less in duration. Seven (23%) were more than 20 minutes, but less than an hour in duration. Mealtimes did not appear to be an issue with these restraints. None of the forms indicated that individuals asked for or required toilet breaks. There were some indications that water was offered. In the two restraint episodes that exceeded one hour, both were mechanical restraints to prevent SIB with individuals. More specifically: ▪ Individual #399 was restrained on 6/20 at 10:50 a.m. with wristlets to prevent injury to an IV or catheter. She was checked every 30 minutes, and released every two hours for motion/exercise for 10-15 minutes each time. No meal appeared to have been offered at noon, but a meal was offered at 6 p.m. One offer of fluids was made at 10 p.m. There were two indications of release at 9 p.m. and at 11:30 p.m., indicating the procedure was complete. There were no nursing evaluations and no shift change reviews at the end of the 6 a.m. to 2 p.m. shift. ▪ Individual #146 was restrained on 6/21/10 at 9:45 p.m. with mitts, according to	Noncompliance

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		the Restraint Checklist. Staff checked his restraints during the night every 30 minutes for circulation. He was checked at 6:00 a.m. on 6/22/10 by the nurse and released. From the documentation provided, it was not clear whether there was a medical order for these two restraints, called "noncontingent" restraint, or whether there was a plan in place to fade them over time. Individual #505 was restrained in a wrist-to-waist restraint on 6/25/10 at 4:00 p.m. with two-to-one staffing. He thrashed about in order to get out of the restraints and hit his head on an unknown object. It is difficult to imagine how he could have hit his head on an unknown object with two staff responsible for watching him. It was encouraging to see that most individuals were restrained for short periods. However, it will be important to assure that documentation of individuals' supervision in restraints is accurate and consistent with regard to when steps are taken to assure that the individual in restraint has been given breaks for toileting and meals, and that appropriate orders are in place for individuals with non-contingent medical restraints. For these reasons, the Monitoring Team concurs with the Facility's POI that there is not substantial compliance with this provision at this time. From a nursing perspective, a review of 87 episodes of restraint for 16 individuals showed documentation indicating that in 85 episodes (98%) the individual was checked for injury following the restraint episode. During the baseline visit, members of the Monitor Team were introduced to Individual #146 who wore mittens continuously while asleep. These were used as protection due to serious self-injurious behavior. Guidelines required the staff to check the Individual throughout the night to ensure that the mittens were securely in place. Discussion with staff at the time indicated that the individual did not attempt to remove the mittens and the required checks only disrupted his sleep. Further discussion ensued regarding a fading of the checks with ongoing review regarding the need for the continued use of the mittens. The Facility is to be commended for initiating a change in the guidelines regarding the use of this non-contingent restraint. Effective 3/4/10, a memo was circulated in which staff were advised to no longer interrupt the individual during his sleeping hours. The plan was for a nurse to complete a check within 30 minutes of his waking.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than	Facility policy at Section II.J.5required the individual's team to conduct a review of restraints used more than three times in any rolling thirty-day period.	Noncompliance

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	medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	An incident that occurred in the weeks prior to the Monitoring Team's visit warrants particular attention as it relates to the individual's treatment plan and the use of multiple restraints. During this incident, Individual #79 was placed in restraint multiple times. Based on staff report, in the weeks preceding this incident, she engaged in other incidents in which restraint had been attempted due to her creating situations that had placed her and others at risk. The restraint techniques used at the Facility often were unsuccessful, because the individual had learned to drop to the ground, making effective restraint difficult. It did not appear, however, that despite other incidents in which she and staff had been injured, and restraint had been attempted/used that her team had assessed her adequately, and/or developed adequate plans to protect her, her peers, and staff. During the Monitoring Team's visit, several staff asked to speak with members of the Monitoring Team to voice their concerns over the appropriateness of the placement of Individual #79 at the Facility, and their ability to effectively support the individual's growth and needs. Late in the afternoon on the day of most recent incident, the individual became upset/agitated and proceeded to engage in serious self-injurious and aggressive behavior that continued over several hours. As staff tried to protect the individual, injuries occurred to the individual, and at least five staff members. Assistance was requested from support staff, the individual's housemates were moved to another location, and eventually the individual was transported to a state mental health hospital. The direct support professional who requested a meeting indicated that she felt that staff had been poorly trained/prepared to work with this individual, and she stated that it took approximately one hour for additional staff to arrive after the call was placed to report an emergency situation. In a meeting between management staff and direct support professionals that a member of the Monitoring Team attended, it was revealed that staff were not using the correct procedure to elicit an immediate response. After talking with direct service and support staff, members of the Monitoring Team met with the Assistant Facility Director. At that time, the following recommendations were made: ▪ An immediate debriefing meeting, involving administrators, medical personnel, infection control specialists, and psychology staff, should have been held with the staff involved. ▪ Before the individual left the state hospital, a comprehensive evaluation should be completed. This evaluation should include assessment of cognitive ability and adaptive behavior skills, mental illness, and should rule out any learning disability. ▪ If the Individual was to return to the Facility, the following should be in place: 1) a comprehensive behavior support plan that included a rich array of antecedent and preventative measures, a dense schedule of reinforcement, and clearly delineated steps to follow should problems develop; 2) weekly review of the plan with members of the interdisciplinary team including members of the direct support staff; 3) guidelines to follow should the individual refuse to take	

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		prescribed medication that was necessary to ensure her continued good health; and 4) an emergency plan should restraint or transfer of the individual become necessary. A review of the report, Restraint by Facility 1/1/10 through 6/30/10 indicated that of the 32 individuals restrained, 14 were restrained more than three times in a rolling thirty-day period. These numbers were down from the 41 individuals restrained, and 22 who were restrained more than three times in 30 days from July through December 2009 that were referenced in the Monitoring Team's last report. A review was completed of the action taken for the following individuals: Individual #43, Individual #438, Individual #81, Individual #505, Individual #313, Individual #310, Individual #486, and Individual #324.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Although Psychological Updates were available for Individual #43, Individual #505, Individual #313, Individual #310, Individual #486, and Individual #324, in every case, their last Psychological Evaluation was outdated. Additional details are provided below with regard to Section K.6 of the SA.	Noncompliance
	(b) review possibly contributing environmental conditions;	Structural and Functional Assessments were completed for two of the eight individuals (25%), including Individual #505 and Individual #486. Feedback regarding these assessments is provided below with regard to Section K5 of the SA.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Structural and Functional Assessments were completed for two of the eight individuals (25%), including Individual #505 and Individual #486. Feedback regarding these assessments is provided below with regard to Section K5 of the SA.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Structural and Functional Assessments were completed for two of the eight individuals (25%), including Individual #505 and Individual #486. Feedback regarding these assessments is provided below with regard to Section K5 of the SA.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that	All of the individuals (100%) did have Behavior Support Plans. General feedback regarding Behavior Support Plans is provided with regard to Section K.9. However, as noted above, only two of these plans had the benefit of Structural and Functional Behavior Assessments. Without such information, teams did not have adequate tools to ensure that the BSPs addressed the needs of the individuals. Safety Plans that defined the type of restraint to be used under what circumstances were completed for four of the eight individuals (50%), including Individual #81, Individual #505, Individual #310, and Individual #324. Feedback on Safety Plans is provided below with regard to Section K.11.	Noncompliance

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	initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	There were no plans for a review of treatment integrity at the time of the visit. This is discussed in detail with regard to Sections K.4 and K.12 of the SA.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	As described below, each of the eight individuals had changes made to their PSPs. However, only one individual's Behavior Support Plan was modified (Individual #310). As noted above, adequate assessments generally had not been conducted, so evaluating whether the "necessary" changes were made, as required by the SA, could not be done. The following summarizes the actions taken for each individual in the sample for whom restraint was used more than three times within 30 days: ▪ Individual #43 had an addendum to his Personal Support Plan, dated 3/11/10. In response to the increase in his problem behavior and as a result three or more occurrences of chemical restraint within a 30-day period, he was transferred to Big Spring State Hospital for evaluation. ▪ Individual #438 had multiple restraints in February. Although he had two addenda to his Personal Support Plan dated in May, the issue was related to his level of supervision. No apparent changes were made to his Behavior Support Plan due to the high rate of restraint. ▪ Individual #81 experienced multiple restraints between April and May. He had one addendum to his Personal Support Plan, dated 6/30/10, which involved a review of his level of supervision. ▪ Individual #505 returned to the Facility in March from Big Springs State Hospital. Since that time he had multiple restraints, with a minimum of once weekly addenda to his Personal Support Plan. Discussion focused on a review of	Noncompliance

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		his Behavior Support Plan and the type of restraint employed, consideration of health factors that were possibly contributing to his self-injurious behavior, recommendation for Computed Tomography (CT) scans, and a request for presentation of his case at a Grand Round discussion. It appeared that staff were taking all steps possible to help this Individual and to reduce his time in restraint. On 5/11/10, a concern was raised when reference was made to four-point restraint. This was not listed as an approved mechanical restraint in the Facility's policy (page 17). ▪ Individual #313 had experienced multiple restraints in the spring of 2010. There were several addenda to her Personal Support Plan written in June and July. A proposal was made to increase her time in work, adding a job she was reported to enjoy in the early evening hours. Other discussion related to her level of supervision and additional efforts to expand her time engaged. ▪ The Behavior Support Plan for Individual #310 was revised once in January and again in March. Revisions focused on medication changes. An addendum to his Personal Support Plan was implemented on 7/13/10. Due to this Individual's terminal illness, a decision was made to amend and simplify his Behavior Support Plan. ▪ Although Individual #486 had experienced numerous restraints, the Facility indicated there had been no addenda to either his Behavior Support Plan or his Personal Support Plan since his annual review held on 7/30/10. ▪ Individual #324 had multiple restraints between late May and late June. Her Personal Support Plan was amended at the end of June, noting a change in her schedule of reinforcement allowing her to access soda every weekday. Additional addenda occurred in July in which her level of supervision was reviewed and her medication was changed.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Review of Incident Management Review Team (IMRT) Minutes related to the sample of 39 restraint reports from the period of January 2010 through June 2010 indicated that all were reviewed by the IMRT within three business days with one exception. Individual #310 on 6/25/10 at 1:12 p.m. was restrained in a basket hold and horizontal side lying physical hold. However, no reference to this event was found in the IMRT minutes for the succeeding days. The IMRT meeting minutes only recorded a brief description of the event, but they were improving. Examples showing the limited discussion and/or documentation regarding restraint episodes included: ▪ On 5/12/10, the IMT minutes under restraint included reference to Individual #132 as "basket hold to horizontal – upset and destroy golf cart; aggressive to …" on 5/11/10.	Noncompliance

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		▪ On 6/30/10, the meeting notes included reference to restraint of Individual #313:" basket hold, aggressive; hitting staff with hanger; talking about wanting to go back to Big Springs." ▪ The IMT minutes for 5/24/10 included review of a chemical restraint of Individual #43. They noted "chemical – aggression to staff." No information was provided with regard to the type of aggression, what steps were taken to deescalate the behavior, or if the PBSP was followed appropriately. ▪ At the IMRT meeting attended on 8/3/10, there was some discussion of the causes of restraint of an individual who became upset over salty noodles. Some limited improvement was seen. For example, in the 6/11/10 minutes under the restraint section, the note on Individual #310 read: "Baskethold/two man horizontal – agitated, screaming, SIB to self – bruised his forehead; Chemical; discussed the possible need for hospice care." This note, while still brief, recorded the issues leading to restraint and indicated the IMRT discussed further action. Further information was still needed regarding the less restrictive methods staff used prior to implementing restraints, and an analysis of whether staff's actions were consistent with the individual's BSP and/or Safety Plan. The IMT reviews were taking place within the required timeframe of three business days. The information included in the minutes of the meetings was becoming more descriptive, and provoking more discussion than was noted in February 2010. However, as illustrated by the examples above, not every restraint was being reviewed thoroughly to obtain a good description of the circumstances under which the restraint was used, and to ensure that recommendations were made to reduce potentially the need for restraint in the future. To be effective, much more specific information needs to be reviewed and analyzed, and appropriate recommendations made to individuals' teams. The Facility's POI identified noncompliance with this component of the SA. This is consistent with the Monitoring Team's findings.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. In order to ensure that pertinent clinical information is available for review and analysis, the section of the Restraint Checklist on alternative measures that were attempted prior to the use of restraint should be modified to require more specific information, particularly with regard to implementation of the individual's BSP or Safety Plan.
2. Staff need to be provided with training to ensure the implementation of the requirements that were addressed through adoption of a restraint policy in June 2010 that release from restraint be based on safety considerations, not on an individual being calm and quiet. This also may require modifications to the Restraint Checklist.
3. The Restraint Reduction Committee should continue its emphasis on discovering the underlying causes for individuals with the most frequent

use of restraint, and addressing the causes through the implementation of corrective action plans.

4. Attention has been given to those individuals for whom restraint, particularly chemical restraint, is employed frequently. This effort should continue until chemical restraint is used infrequently and only when necessary.
5. Efforts should continue to ensure the development of appropriate strategies to minimize or eliminate the use of restraint for individuals who have difficulty tolerating medical and dental appointments.
6. Work on developing a new PSP form and process was underway, and ABSSLC was piloting the new process. This work should continue to create a process that can focus in on the factors in an individual's life that need to change so the individual can be free of restraint.
7. The Facility should review restraint records and investigate the potential causes for the lack in both timely completion of and documentation of face-to-face assessments, and a corrective action plan should be developed to address the issues identified. For example, staff training on restraint should be reviewed to assure that clear directions are being given on the importance of accurately reporting, and keeping careful watch over anyone in restraint. Notification of and availability of nursing staff also should be reviewed to determine what might be preventing them from conducting timely assessments of individuals in restraint.
8. Recommendations regarding the schedule of completion for Structural and Functional Assessments are provided below with regard to Section K of the SA. In prioritizing the need for the completion of Structural and Functional Assessments, it would also be advisable to give priority to those individuals who experience high rates of restraint.
9. Psychological evaluations should be completed at a minimum of once every five years. As guidelines are established to ensure compliance to this requirement, priority should be given to those individuals who experience high rates of restraint.
10. Staff should review all cases in which individuals are placed in restraint more than three times within a 30-day period. Points of discussion and plan revisions should be documented with on-going review of effectiveness.
11. As psychology staff develop plans for assessment of treatment integrity in the application of behavior support plans, consideration should be given to simultaneously assessing staff competence in the application of restraint.
12. The IMRT's review of restraint episodes needs to be more thorough, and include analysis of the potential causes leading up to the restraint. As appropriate, recommendations should be made to individuals' teams to reduce potentially the need for restraint.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #021: Protection from Harm – Abuse, Neglect, and Incident Management, dated 6/18/10; o DADS Policy #002.2: Incident Management; o ABSSLC Policy #021: Protection from Harm-Abuse, Neglect and Incident Management dated 6/18/10; o ABSSLC Policy #002.2: Incident Management; o ABSSLC Plan of Improvement, dated 5/17/10; o ABSSLC Supplemental Plan of Improvement, dated 5/17/10; o ABSSLC Trend Analysis Report for 3/1/10 through 5/31/10; o Department of Families and Protective Services: Presentation to DOJ SSLC Monitors, Adult Protective Services Compliance with the Settlement Agreement between the Department of Justice and the State of Texas, by Karl Urban, on 6/3/10; o Incident report forms on individuals who experienced incidents or abuse/neglect allegations during the six months preceding the review; o ABSSLC Incident Management Review Team Meeting records, from 4/1/10 through 7/9/10; o Incident report forms and data on individuals who experienced incidents or abuse/neglect allegations during the six months preceding the review; o ABSSLC Injury Trending for 3/1/10 – 5/31/10; o All injuries investigated from 1/1/10 through 7/1/10 at ABSSLC; o Reassignments list in response to TX-AB-1008-III.29; o Department of Family and Protective Services (DFPS) records of abuse, neglect and exploitation investigations, and related ABSSLC unusual incident Investigations for the following individuals for incidents or allegations occurring on the following dates: Individual #274 on 6/26/10, and 7/9/10; Individual #524 on 5/15/10; Individual #425 on 6/22/10; Individual #287 on 6/21/10; Individual #289 on 6/20/10; Individual #215 on 6/18/10; Individual #154 on 5/23/10; Individual #4 on 5/24/10; Individual #134 on 6/22/10; Individual #94 on 5/19/10; Individual #303 on 5/22/10; Individual #399 on 5/2/10; Individual #209 on 6/14/10; Individual #310 on 5/8/10; Individual #252 on 5/10/10; Individual #218 on 5/15/10, and 5/18/10; Individual #540 on 5/14/10; Individual #62 on 6/19/10; Individual #100 on 7/29/10; Individual #517 on 7/22/10; Individual #39 on 7/15/10; Individual #477 on 7/15/10; Individual #439 on 7/9/10; Individual #267 on 6/7/10, and 7/3/10; Individual #319 on 6/29/10; Individual #163 on 6/23/10; Individual #94 on 5/20/10; Individual #479 on 5/12/10, and 5/16/10; Individual #545 on 6/3/10; Individual #504 on 5/5/10; and Individual #438 on 5/2/10; and

	○ ABSSLC unusual incident investigation records for incident tracking numbers: #2264, #2235, #2198, #10-06-017, #2217, #2177, #10-05-009, #2120, #2077; #10-03-028, #2156, #2134, #2249, and #2152; and ○ Personal Support Plans (PSPs), and related assessments for: Individual #505, Individual #310, Individual #79, Individual #443, Individual #540, Individual #399, Individual #111, Individual #538, Individual #49, Individual #486, Individual #481, Individual #218, Individual #272, Individual #167, Individual #243, Individual #455, Individual #278, Individual #230, Individual #4, Individual #534 ▪ **Interviews with**: ○ Luee McCreary, Incident Management Coordinator; ○ Sam St. Clair, Quality Assurance Director; ○ Cathy Hennington, Director of Psychology ○ David Daniel, Systems Initiative Coordinator; ○ Tom Farrell and Tommy Johnston, Investigators; and ○ Richard Gonzales, Silbia Sanchez, Larry Jones, and Christian Ramsey, Campus Administrators ▪ **Observations of**: ○ Living Units: 6700, 6460, 6450, 6300, 6350, and 5961 ○ Incident Management Meeting led by the Facility Director, on 8/3/10
	Facility Self-Assessment: The ABSSLC Plan of Improvement was submitted as the Facility's self-assessment. For each provision of the Settlement Agreement, there was a rating of either substantial compliance noncompliance. The Quality Enhancement Division was working with a monitoring tool in draft, "Texas Settlement Agreement Monitoring Instrument," and Program Compliance Monitors (PCMs) had begun to apply the tool to investigation records. While the sample was small, the application of the tool was allowing PCMs to field test the tool and to determine where adjustments in the tool may be needed. The plan was for both Program Compliance Monitors and staff responsible for the SA section to apply the tool in order to check for reliability of the instrument.
	Summary of Monitor's Assessment: There had been significant progress with regard to the implementation of Section D of the SA since the last monitoring, including: ▪ Policies on Abuse/Neglect and Incident Management had been adopted; ▪ Some 98% of staff had been trained in abuse and neglect reporting; ▪ Investigators had been trained in Root Cause Analysis, and the Incident Management Coordinator had begun to use the process. This had begun to generate cooperative problem-solving across disciplines; and ▪ Cooperation with DFPS and law enforcement appeared to be working well. Areas that needed continued effort included: ▪ Timeliness of reporting incidents and allegations and timeliness of reporting to related offices and agencies; ▪ Posters providing information to individuals on their rights needed to be posted in residences and

	other campus buildings, and staff need to be trained on why they are important; ▪ The timeliness of the start of investigations, as well as the submission of the final reports continued to need improvement; ▪ The thoroughness of the Facility's death investigations/reviews needed to be improved substantially; and ▪ The thoroughness of the follow-up with regard to unusual incident investigations, particularly death investigations needed to be improved. Failures to do so placed individuals, as well as staff at risk.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The DADS policy on abuse, neglect and incident management was revised on June 18, 2010. The revision separated the Abuse/Neglect/Exploitation policy, DADS Policy #021, from the Incident Management Policy that now appeared as DADS Policy #002.0 These policies were reviewed and found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below The DADS abuse, neglect and exploitation rules and incident management policy stated that abuse, neglect and exploitation were prohibited. The SSLCs were required to comply with these State policies and rules. ABSSLC adopted the DADS Policies 002.1, and 021 in whole on 6/18/10.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such	According to ABSSLC Policy #002.2.IV, staff were required to immediately (or within one hour) report abuse, neglect or exploitation to the Texas Department of Family and Protective Services (DFPS) by calling an 800 number. Based on the 35 investigation reports reviewed, reporting appeared to be timely in 33 (94%). The policy required that the 1-800 number be posted in work areas. Each employee's ID badge included the number as well, although not one of the ten staff interviewed referred to the badge when explaining how to report abuse, neglect and exploitation. Staff interviewed did indicate that the number was posted, and that it could be found by the	Noncompliance

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	other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	phone in the office. Policy #002.2.IV stated that other incidents such as deaths must be reported to the unit supervisor, campus coordinator and nurse, and the Director must be notified within one hour. In the 14 Unusual Incident records reviewed, it appeared that reports were not made within one hour for four of them (Incident Tracking #10-05-009, #2077/10-03-027, #10-03-028, and #2152), or 28% of the time. In the combined DFPS abuse records and facility unusual incident records, it appeared that for Individual #274 on 7/9/10, the report of his fall in his bedroom at 3:15 p.m. was not reported until 10:22 p.m. For Individual #62, the initial report of her fall occurred three hours after the event. For Individual #252, the report of restraining him by holding his wheelchair did not occur within an hour of occurrence. Standardized reporting forms appeared to be in use. The Facility POI did not find this element to be in compliance, which is consistent with the Monitoring Team's findings. In reviewing ABSSLC unusual incident records with and without connection to DFPS abuse records, there were a number of times when reporting appeared to be delayed.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	In ABSSLC Policy #002.2 III.A, a staff member who discovered or learned about an unusual incident must take action to protect the individual, arrange for a nurse to assess the individual for injuries, and preserve the physical evidence. ABSSLC Policy #021.X required reassignment of the alleged perpetrator away from direct contact with the alleged victim. In all of the abuse cases reviewed, alleged perpetrators were promptly reassigned. A review of the records of staff reassigned between January and June 2010 indicated that there had been 224 instances of staff being reassigned. During a similar time period, (December 2009 through May 2010), there were 228 allegations of abuse or neglect, which suggested the Facility was carrying out this responsibility. The IMRT reviewed reports of abuse, neglect, exploitation and serious injury on a regular basis, reviewing actions taken and instructing staff on additional actions to take when appropriate. However, it did not appear that the actions taken were consistently sufficient to ensure the protection of individuals served. For example: ▪ Individual #79 had engaged in a number of incidents that had placed her and others at risk. At the time of the review, she had been hospitalized after attempting to injure herself, and, in the process, injuring a number of staff. A number of individuals who lived in the home with Individual #79 had witnessed portions of the incident, and had been aware that staff were	Noncompliance

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		injured. Some of the direct support professionals reported that the other individuals living in the home were scared and upset. It was not until several days after the incident occurred that steps were identified to address the needs of the other women in the home. The Facility POI found this element to be in substantial compliance except for taking appropriate personnel action where it was determined that a mandatory reporter had failed to report abuse. Due to the fact that the POI did not reference the data that was used to make compliance determinations, it was difficult to determine how this conclusion was reached or what the extent of the problem was. The Monitoring Team's review found evidence of delayed reporting, but the reports were eventually made. It was not clear to the Monitoring Team that adequate action was being identified as necessary and taken to protect all individuals involved in significant incidents.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	ABSSLC Policy #021.II required competency based training on preventing abuse and neglect (ABU0100) during pre-service and annually thereafter. Pre-service training included four hours of training on unusual incidents and prevention of abuse/neglect/exploitation. According to the ABSSLC POI, this provision was in compliance except that not all staff had been trained on abuse/neglect policies (95% had been trained), and not all observations and interviews showed that abuse and neglect were reported as required. During the on-site review, a current copy of the "Course Delinquency List" was requested for the course on abuse and neglect. The report dated August 3, 2010 revealed five staff members out of 1,442 or less than 1% who was not up-to-date on this course. The ABSSLC POI found this element to be in substantial compliance except for documentation of training completion. However, the current "Course Delinquency List" showed that nearly 100% of staff had taken the required training. This element is in substantial compliance.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement	DADS policy #021 required staff be trained on abuse, neglect and exploitation upon hiring and annually thereafter. The policy included a requirement that staff sign a statement acknowledging their responsibilities at the time of employment and every year thereafter. The Facility policy did the same. Statements acknowledging the obligation to report abuse were present for newly hired staff and current staff in a sample of ten recent hires and 10 current staff. Ten staff interviewed were able to explain how to report abuse and neglect, by calling the	Substantial Compliance

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	that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	1-800 number posted, though, three staff indicated the poster was "somewhere," but they would have to look for it. None of the staff interviewed referenced the reporting information on their badge when explaining what to do. Management staff later indicated that all badges carry that information and displayed their badges as evidence. However, even if the badges carry the information, if staff have not been trained to look there for the information, the badges are not helpful in ensuring reporting Staff interviewed were clear on their obligation to report abuse and had reported abuse themselves. It was not clear that they understood all the signs and symptoms of abuse, but they appeared to understand that when in doubt it was best to report. Given that a sample of staff had signed the form required by the SA, and that a sample of staff were able to correctly explain what their reporting obligations were and how to report abuse, the Facility is in substantial compliance with this provision.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A resource guide for individuals, primary correspondents, and Legally Authorized Representatives (LARs) was required in DADS Policy #021.1.M. The Facility's POI indicated that this was an area in which they were not in compliance with regard to the implementation of policy because their records did not demonstrate that LARs received support when reporting, nor did the records show follow up on actions taken. The records reviewed showed that some individuals were aware of the reporting system and had made allegations of abuse and neglect, and the Facility and DFPS treated those allegations exactly the same as allegations made by staff. Under DFPS policy, the Facility had a choice to use a streamlined process for reports by individuals when there was evidence to suggest the individuals had made unfounded allegations in the past. The Facility and local Adult Protective Services office had chosen not to implement this process. This resulted in full investigations of all allegations being conducted. QMRPs were supposed to supply a copy of the resource guide to individuals and their guardians, and to discuss the subject of rights with individuals at or before each annual planning meeting. This appeared to have been done in at least nine of the 20 PSPs reviewed, or approximately 45%. However, it did not appear that this was yet standard process at the Facility, and it was not clear how LARs received support to report, and if or how follow-up actions were tracked. The Facility was not yet in substantial compliance with this element.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of	The DADS policy #021, Section I.F dated 6/18/10, on abuse, neglect and exploitation required a rights posting.	Noncompliance

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	individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	In only two of six residences (33%) visited was the "You Have the Right" poster posted. In Apartments 5961, 6450, 6521, and 6700, there were no "You Have the Right" posters in evidence. Where posters were not obviously displayed, staff were asked to point them out and they could not. There were posters in some residences that displayed the picture of the rights advocates and provided a number to call for help with exercising rights, but did not include a statement about what the individuals' rights were.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	DADS Policy #021.IV.E and the ABSSLC companion policy addressed referrals to law enforcement. When allegations of Abuse/Neglect and/or Exploitation (A/N/E) were made to the DFPS, it was their responsibility to determine when to report to law enforcement. In 35 DFPS reports reviewed, six were referred to the Office of the Inspector General (OIG), and the files noted that there was evidence of criminal activity in two. In one (Individual # 252 on 5/10/10) the file note indicated that OIG found evidence of criminal activity, though it was not clear what that meant in terms of follow-up action. In one, Individual #62 on 5/15/10 had fallen from a bathing table resulting in her death. The record indicated it was an "OIG case." However, it did not appear to affect the conduct of the DFPS investigation. In a random review of 11 DFPS records, referrals to law enforcement were made in five or 45% of the records. In one of the records, ASSLC had reported to OIG when DFPS had not. Since procedures were in place for referring to law enforcement, and review indicated that they were being appropriately applied, this subsection is in substantial compliance.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	DADS Policy #021.IX and the same section of ABSSLC Policy #021.IX prohibited retaliation by staff or agents of the Facility, and set forth recourse for those who believed they had been retaliated against. Staff were instructed to report retaliation to their supervisor, or if that was not appropriate, to the Facility Director. Calls to the Attorney General or the Office of Inspector General were referenced in the policy as additional recourses to retaliation. According to the Director of Quality Assurance, residents, families and other non-employees could go directly to the Facility Director to report any threats or to the Human Rights Office. If the threat was against the resident, they could contact DFPS via the 1-800 number. As noted in the last monitoring report, it was not clear whether or not staff felt free from fear of retaliation when reporting incidents and abuse. In a DFPS investigation #10-03-	Substantial Compliance

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		027 the investigator noted that one staff member alleged other staff pressured her to collude in a statement about what was going on when Individual #8 injured her shoulder. The fact that she was pressured, suggested that more pressure might result because she declined to cooperate. I n interviews with staff at least two indicated that they did worry about retaliation. Both, however, understood their options to report retaliation. The POI noted that reports of retaliation would be investigated if they occurred, giving no indication if they ever had occurred. It would be helpful to know how many allegations of retaliation were reported, to whom, whether they were investigated, and with what result as part of the evidence package supporting the POI. While concerns about possible retaliation were identified in this review, no actual instance of retaliation was evident. This subsection is in substantial compliance.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The DADS policies #021 and #002.1 did not appear to address fully the audits of injuries to determine what should be reported for investigation. Although the DADS policy called for the completion of audits semi-annually, it did not describe what an audit report entailed, what information was to be reviewed and/or by whom, nor did the companion ABSSLC policies. The POI indicated that audits had been conducted of observation/progress notes, injury reports, shift logs and Management Team Meeting minutes to determine if all significant injuries have been reported. This audit was planned to occur semi-annually and was under the direction of the Quality Enhancement Director. A copy of any completed audits was not available, however, they were contained reportedly within Incident Management Team Reports. It would be helpful in future to provide the reference to the date of the audits in the POI and a copy of the meeting notes, showing the discussion that took place. There was an Injury Trending Reported 3/1/10 to 5/31/10, that displayed an accounting of all injuries, both serious and non-serious for the three-month period (1753 total). Injuries were analyzed by type (most frequent were scratches, bruises and abrasions), by cause (unknown, scratches, and slips and falls were most frequent), by home, by building and by room within the building. There were analyses by shift, day of the week, and by the four individuals receiving the most injuries. Recommendations followed the analyses with priority given to addressing the four individuals with the most injuries and action steps to begin the address the issues. This appeared to be a reasonable way to begin to address the identified issues, and provided a means for following progress in both the implementation of the actions and subsequent analyses of injuries. What the analysis did not do was identify patterns of injuries that suggest possible abuse or neglect and report the patterns to DFPS for investigation. For example, building 6350	Noncompliance

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		was reported to have had approximately 130 injuries. The fact that so many injuries occurred in one building suggested that the environment or the grouping of individuals might be contributing to the injury rate, or possibly as the result of neglect. However, this was not identified as a trend requiring further analysis and review. The analysis did not appear to have been used to crosscheck the number of serious injuries to the Unusual Incident Investigations for the same period to ascertain whether all serious injuries had been investigated.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DADS Policy at 002.2.II.B and C required Facility investigators to have training in investigations and in working with people with developmental disabilities (courses CIT0100 and MEN0300). The policy did not indicate that the training should be competency-based, but a review of the course indicated they were. DADS Policy at 002.2.I.H required Facility investigators to be outside the direct line of supervision of the alleged perpetrator. DADS Policy at 021.II (Staff Training) indicated that all staff who investigated A/N/E would have training in working with individuals with intellectual disabilities. DFPS indicated in a conference call with the Monitoring Teams, and in accompanying power point presentation that DFPS staff had: ▪ Instructor Lead Skills Development (ILSD) Interviewing Module – half an hour introduction on principles of how to interview persons with developmental disabilities (DD); ▪ ILSD Terms Module – three hours on mental illness and mental retardation terminology and classification; ▪ Field Training -- two Web-based training modules on mental illness and mental retardation; and ▪ Instructor Lead Advanced Skills Development (ILASD) Interviewing Module – 3.5 hours how to specifically interview someone with DD.	Noncompliance

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		There were six investigators at the DFPS NW District office assigned to work on abuse investigations at ABSSLC. The records of their training, provided by DFPS indicated that: ▪ Three clearly had received the training as indicated by DFPS; ▪ Three did not have courses with the titles specified in the DFPS call. However they did have investigation training classes and some classes related to people with developmental disabilities such as "MH&MR [Mental Health and Mental Retardation] Overview – APS Investigator Role." ABSSLC had an Incident Management Coordinator and two full-time investigators, supplemented by four Campus Coordinators, and a number of staff in other departments who completed investigations if needed. When the incident involved medical issues, the Quality Enhancement Nurse was available to complete investigations. When the incident involved choking, a speech therapist was available to complete the investigation. A review of the training of those who were assigned to complete investigations revealed that: ▪ Thirty-two staff had taken the CIT0100 Comprehensive Investigator Training, including the Incident Management Coordinator, the two full-time investigators, the Quality Enhancement Nurse, two speech therapists, and an occupational therapist. ▪ Twenty staff had taken CS10100: Conducting Serious Investigations: Labor Relations Alternatives, including the Incident Management Coordinator and the two full-time investigators. None of the therapists or the Quality Enhancement Nurse appeared to have taken this course. ▪ Twenty-five staff had taken RCA1000: Root Cause Analysis class. The Facility POI indicated there was no documentation to show that Facility investigators were outside the direct line of supervision of the alleged perpetrator. However, review of the Unusual Incidents in the sample did not reveal a situation where an investigation was being conducted by a perpetrator's supervisor. The investigators who worked for the Incident Management Coordinator did not supervise other staff, meaning they would not be in the line of supervision. The nurse who worked for Quality Enhancement was outside the line of supervision of most staff. The therapists' job was to provide therapy to individuals and advice about therapy, outside the line of supervision of most staff. It was noted that, while the nurse and the therapists, who conducted investigations of deaths and choking incidents respectively, had had the required CIT0100 class in investigating, they had not had the more robust course, CS10100. ABSSLC should consider if it would be prudent to have the nurse and therapists obtain the advanced training to ensure consistent investigations, or whether to assign these investigations to	

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		the investigators and have the therapists provide support. The Facility Investigators could complete investigations, for example, of choking incidents, and interview therapists as experts.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, referred at I.D to cooperation with DFPS, and Section V.A.2.d also referred to cooperation with DFPS in the conduct of investigations. Policy 002.1 at D provided for reporting to law enforcement, and required staff to abide by all instructions of the law enforcement agency. ABSSLC Policy # 002.1 did the same. There was nothing in the records of abuse investigation or unusual incident investigations to suggest a lack of cooperation between DFPS and facility investigators, or between investigators and law enforcement, or between investigators and the Office of the Inspector General. In fact, the records indicated that great care was taken to be cooperative. In one record (Individual #439 (on 7/9/10) it appeared the OIG case had remained open since May, pending OIG action, however, the DFPS and ASSSLC portions of the case were completed.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS Policy #021 referred to coordination with law enforcement, and instructed staff to cooperate with all instructions from law enforcement. ABSSLC's companion policy did the same. Based on sample of 35 DFPS abuse investigations, six referrals were made to local law enforcement or to OIG. The record of DFPS investigations and related facility unusual incident investigation contained a section with correspondence with OIG and local law enforcement as appropriate. A review of these notes did not indicate any problems in the cooperative conduct of investigations. The Facility-maintained records were well kept which made it easy to see both the DFPS record with the related unusual incident record. These gave no indications of problems with cooperation between DFPS and the Facility. During an interview, the Incident Management Coordinator reported good cooperation with police and with DFPS on a recent situation involving Individual #79. This incident involved a crisis situation and the inability of staff to contain the dangerous behavior of this individual. The State is found to be in substantial compliance with this requirement, which is consistent with the Facility's self-assessment in its POI.	Substantial Compliance

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	(d) Provide for the safeguarding of evidence.	DADS Policy #002.2.III.D, E, F, and Exhibit B concerning securing evidence, as well as DADS Policy #021.III.B.2-4, and Exhibit B addressed the safeguarding of evidence. The ABSSLC companion policy did the same. In an investigation of a fall of Individual #62 from a bathing table, the table was immediately secured as evidence. In other records it appeared that the evidence consisted mostly of the statements of witnesses, and these were obtained and entered into the computer, with the originals remaining on file. The State is found to be in compliance with this requirement, which is consistent with the Facility's self-assessment in its POI.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DADS Policy #002.2.V required the investigation of a serious incident to commence within 24 hours, and for a report to be generated within 10 days. ABSSLC Policy #002.2 did the same. Both required the Facility Director or the Supervisor of Adult Protective Services to grant a written extension to exceed 10 days to file the report. In 35 DFPS abuse investigations, 17 (49%) were clearly started within 24 hours. To determine this, the date the allegation was reported was compared with the date of the first interview, because no other indication was provided of when or how the investigations began. Although DFPS policy indicated that an investigation was commenced when the Facility was notified that an investigation would be conducted, this did not constitute the actual initiation of an investigation. Twenty-five (71%) were completed within the 10-day timeframe. In eight investigations involving only Facility investigators, it was difficult to determine when the Facility investigation began because information from interviews with staff did not include the date of the start of the investigation, nor the dates of the witness interviews. However the reports were completed within 10 days of the reported date in six out of eight reports (75%). In the future dates of interviews should be included in the facility investigations.	Noncompliance
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly	DADS Policy #002.2.VI set out the requirements for SSLC investigative reports and contained the elements required in this subsection of the SA. ABSSLC Policy #002.2.VI mirrored those requirements. Thirty-six DFPS investigations of abuse and neglect allegations were reviewed, and were generally found to have provided clear bases for their conclusions. A standard format	Noncompliance

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	and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	was used. Some observations of strengths of the investigations include: ▪ Records included substantial information, gathered from witnesses, victims, alleged perpetrators and records; ▪ Each report followed a format that set out the allegation, the evidence list, the witness statements, and other information gleaned from records and logs. The credibility of the information was assessed and a probable version of events described, followed by a conclusion, and concerns and recommendations. ▪ In one investigation involving Individual #524 on 5/15/10, the investigator could not reach a probable version of the events in this allegation involving an unknown alleged perpetrator, in spite of interviews with seven staff, and review of eight documents related to the individual. It appeared that the investigation was aggressively pursued and simply lacked substantial evidence. ▪ In several investigations, the DFPS investigator identified concerns or offered recommendations. For example, in one investigation involving Individual #425 on 6/22/10, it was noted that the staff had not been following the individual's behavior plan. In another, it was noted that staff were signing off on procedures for each other with the result that the records showed procedures being conducted when staff were on breaks. One concern noted was that when there was potential for supervision to have been an issue, this was not consistently investigated. For example: ▪ In one investigation, Individual #289 had fallen without a helmet on his head. It was not clear to staff who was responsible for that individual. What was not clear from the investigation was whether the investigator had extended the investigation to determine whether the supervisor had assured that staff knew their assignments. Of the 14 Unusual Incident Reports examined, all were in a standard format, and most contained sufficient information to draw conclusions. One observation was: ▪ An investigation into a laceration sustained by Individual #252 indicated a peer pushed him in a crowded living room as individuals gathered to go to a dance. It was not clear in the report why Individual #252 was in the room, or if he was known to be disturbed by confusion. These questions were not answered by the investigation. In general both the DFPS investigation reports and many of the Facility's unusual incident investigation reports appeared thorough, leaving few unanswered questions. When there are questions about supervision of individuals, it may be the supervisor who has failed to make the appropriate assignments and this needs to be investigated.	

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		A major concern, however, related to the inadequacy of death investigations. This is discussed below in detail with regard to Section L.1 of the Settlement Agreement. As is discussed in that section of the report, investigations of deaths conducted by the Facility were inadequate, and often failed to identify issues that may have contributed to the deaths. In addition, few resulted in findings or recommendations that the Facility could use to prevent potentially similar occurrences in the future. The Facility self-assessment found that the State was in substantial compliance with this element of the SA. The Monitoring Team found significant concerns with the thoroughness of investigation of deaths, as well as some more minor concerns related the investigation of other significant incident categories. As a result, a finding has been made of noncompliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	DFPS investigation reports were signed by the investigator. The supervisor was reported to be signing off electronically, and so there was no shared record of that signature. As was discussed during a meeting between DFPS, DADS, and the Monitoring Teams, a process needs to be devised to allow the Monitoring Team's to assess this component of the SA. The Incident Management Coordinator at ABSSLC reviewed the DFPS reports, and did on occasion ask for additional information or further investigation. This element will not be in substantial compliance until DFPS is able to provide evidence that the supervision of the DFPS investigations is occurring.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	As is noted above with regard to Section D.3.g of the SA, the Facility's Incident Management Coordinator signed to verify that the report has been properly compiled and presented. The State is found to be in substantial compliance with this requirement, which is consistent with the Facility's self-assessment in its POI.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and	Section 10 of the Unusual Incident Report provided a space for listing immediate actions taken before (when the form is preliminary) or after (when the form is final) the completion of an investigation, whether by DFPS or by a facility investigator. There was also provision for recording longer-term recommendations in Section #13. The Incident Management Team that met daily under the leadership of the Facility Director reviewed all incidents and monitored actions taken to address	Noncompliance

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	track and document such actions and the corresponding outcomes.	recommendations. As a result, many necessary actions were taken promptly and thoroughly. For example: ▪ Individual # 62 fell from a bathing table and subsequently died of her injuries. Similar bathing tables were immediately removed from residences, checked for any possible defects. Before restoring them, new training was provided to staff who would be using them. ▪ Individual # 134 was found unresponsive in his bed and subsequently died. In the process of investigating the death, DFPS investigators discovered that staff were signing off on checklists for each other. The evidence showed that forms were signed indicating procedures had been conducted when staff were actually on breaks or administering CPR. There was re-training of staff on accurate recording as a result. ▪ Individual #15 was found with a laceration on his foot, likely the result of not wearing shoes or having a fungus on his foot. The doctor was consulted, and decision was made to use lotion and encourage wearing of shoes with a follow-up scheduled with the doctor. However, there were serious incidents, including deaths for which adequate follow-up was not taken. This had the potential to place the individuals involved, as well as their peers and staff at risk. For example: ▪ As noted previously, Individual #79 had been involved in a number of incidents that had placed her and others at risk. At the time of the review, she had been hospitalized after attempting to injure herself, and, in the process, injuring a number of staff. Based on the discussions with management staff, it appeared that a number of opportunities had been missed after previous incidents had occurred to put plans and procedures in place to protect the individual, her peers and staff. Some of the essential protections and supports that had not been identified or provided despite her numerous previous incidents included possible revisions to her PBSP, consideration of increased staffing for the home as a whole, contingency plans for medication refusals, modifications of restraint techniques due to ineffectiveness of standard procedures that were taught, training for staff on relevant mental health diagnoses, and more in-depth training for staff on infection control issues. ▪ As is discussed in greater detail with regard to Section L.1 of the SA, minimal numbers of death investigations included recommendations. However, even when the nursing department's review of Individual #161's death resulted in a number of important recommendations, it did not appear that these were addressed. ABSSLC provided three examples of recent disciplinary actions taken in response to investigative findings:	

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		▪ An event on June 3, 2010 resulted in a letter of reprimand on June 30, 2010. ▪ An event on June 10, 2010 resulted in consultation note in the staff member's file on June 21, 2010. ▪ An event on May 15, 2010 resulted in a letter of reprimand on June 30, 2010. Disciplinary actions in the reviewed records appeared to be reasonably prompt. The Monitoring Team's findings were consistent with the Facility's POI that indicated that the Facility did not always take prompt and thorough action to correct and prevent recurrences.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	All requested records were produced quickly. Records were well kept, with reports, evidence and related information filed appropriately. The records were accessible in the paper files with the electronic portions on line. The State is found to be in substantial compliance with this requirement, which is consistent with the Facility's self-assessment in its POI.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	DADS Policy #002.2 at IX set forth requirements for tracking and trending of unusual incidents and investigations by the Incident Management Coordinator. ABSSLC Policy #002.2 contained the same language. ABSSLC provided trending data for allegations of abuse, neglect and exploitation for FY09 and FY10 through the third quarter (May). Allegations were tracked by type, location, and by date and time of day. Allegations were not tracked by staff alleged to have caused the incident or by individual, although there was information on the number of staff and individuals involved. Allegations are not tracked by cause. The trend reports were well done and informative. They provided useful information upon which to base systemic actions to improve services to individuals at ABSSLC. However, they did not yet include tracking by staff or individual, and so were not yet in substantial compliance.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one	The Monitoring Panel has had discussions with the State regarding how this provision of the Settlement Agreement will be assessed. This is necessary due to the confidentiality of the information, and the limited documentation that the State is allowed to maintain regarding the findings of the background checks. To address this, the State will provide the Monitoring Teams with names of staff responsible for the process, so that they can be	Not Rated

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	calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	interviewed, and spreadsheets for each Facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available, this indicator will not be rated.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. When it is identified that staff have failed to report a serious incident or allegation in a timely manner, the Facility should evaluate reasons for staff failing to report, and address the underlying issues.
2. The Facility should move forward with the implementation of the resource guide for families and individuals to assist in the education process about the reporting process for incidents and allegations.
3. The Facility should engage in efforts to reassure staff that retaliation for reporting allegations will not be tolerated. For example, the Facility should continue to strongly train and remind staff at staff meetings, in newsletters, etc., that retaliation will not be tolerated. In addition, on a case-by-case basis, the Facility should evaluate if actions need to be taken when results of investigations are returned and action is taken, for example, disciplinary action. There might be situations in which, based on the results of investigations, and staff's participation in such investigations, and/or due to strained relationships between staff that some staff need to be reassigned to other units or shifts, or supervision needs to be increased to protect against any possible retaliation.
4. ABSSLC should consider if it would be prudent to have the nurse and therapists who conduct investigations obtain the advanced training to ensure consistent investigations, or whether to assign these investigations to the investigators and have the therapists provide support. The Facility Investigators could complete investigations, for example, of choking incidents, and interview therapists as experts.
5. In conducting investigations, the role that supervisors play in ensuring that staff have the tools and skills necessary to complete their jobs should be considered, and, as appropriate, supervisors should be held responsible when staff have not received adequate supervision, leading to negative outcomes for individuals served.
6. Investigators should be trained to be aware of the possibility that a report of one allegation of abuse may lead to the need for investigation of neglect of several residents when the abuse appeared to arise out of chaos and confusion in the home, and it is affecting multiple individuals.
7. The Facility should develop a plan for reducing the numbers of individuals who live and work together who have behavioral issues, as well as identifying alternatives that allow individuals personal space. This needs to be done carefully so as to not disrupt homes on campus that serve individuals with no or few behavioral issues.

8. The IMRT should take steps to address not only the investigated issues, but also the underlying issues that may be contributing indirectly to the incident such as aggression by individuals toward their peers.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003: Quality Enhancement, dated 11/13/09; o ABSSLC Plan of Improvement, 5/17/10; o Performance Improvement Council Guidelines, 6/17/10; o Texas Settlement Agreement Monitoring Instruments in draft for Settlement Agreement Sections C, D, E, F and I, not dated; o Texas Settlement Agreement Monitoring Instruments in draft for Settlement Agreement Section F: completed 7/15/10 for Individual #519; Section C completed 7/16/10 for Individual #464, and Section D completed 7/16/10 on Unusual Incident #2200; o Corrective Action Plans for Section E, undated, by the Quality Enhancement Director; o Corrective Acton Plan for Section D, undated by the Incident Management Coordinator; o ABSSLC Trend Analysis Report: Allegations of Abuse/Neglect/Exploitation for Quarter 3, FY10; o ABSSLC Injury Trending, from 3/1/10 through 5/21/10; o ABSSLC Unusual Incidents Trend Report, from 3/1/10 through 5/31/10; o ABSSLC Restraints Trend Analysis, 3/1/10 through 5/31/10; o Presentation Book for Quality Enhancement; o Performance Improvement Council Meeting notes, dated 1/25/10, 3/29/10, 4/19/10, 5/17/10, 6/7/10, and 6/21/10; o ABSSLC Quality Enhancement Plan, revised 6/17/10; o Leadership Council notes, dated 2/1/10; o ABSSLC Incident Management Review Team Meeting records, from 4/1/10 through 7/9/10; o Monitoring tools associated with the Quality Enhancement Plan; ▪ **Interviews with**: o Nancy White, Quality Enhancement Nurse, substituting for Sam St. Clair, Director of Quality Enhancement; o David Daniel, Settlement Agreement Coordinator; and o William Whitaker, Renay Kellun, Tracy Gandee, Jim Francisco, and Jeremy Atkin, Program Compliance Monitors ▪ **Observations of**: o Incident Management Review Team Meeting, on 8/3/10; Performance Improvement Council Meeting, on 8/2/10
	Facility Self-Assessment: Facility Self-Assessment: The POI for Section E of the SA indicated that the Facility was not in compliance with most of the requirements of the SA. The area in which the self-assessment indicated the Facility had made progress toward compliance was in the development of policies to guide the quality enhancement activities of the Facility. The compliance ratings appeared to be in concert with the findings of the Monitoring Team, and indicated that the foundation for a sustainable

	quality enhancement system was being carefully laid down.
	Summary of Monitor's Assessment: There had been considerable progress since the last monitoring visit, including: ▪ A Quality Enhancement Plan had been developed; ▪ Quality monitoring tools had been adopted, were being tested, and modifications were under development to share at the State level; ▪ Trend reports and analyses had begun to be provided to the units and residences; ▪ The Program Improvement Council was focused on the Settlement Agreement, and what needed to be done to come into compliance; and ▪ A process for the development and implementation of Corrective Action Plans (CAPs) to address outstanding elements of the SA was underway, with first plans having been completed for most sections of the SA. Quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, some modifications had been made to these tools, and they were being field-tested. It was positive that the Facility was making use of the tools developed by the Monitoring Teams. However, while on site, the Monitoring Team discussed with Facility staff some of the additional modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to: ▪ The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. ▪ The items on the tools have not been weighted, but would need to be if they were going to be used to generate cumulative scores. ▪ Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators. ▪ At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement

	Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. Trending of some basic quality indicators was being conducted. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by ABSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. The next step will need to be responding to the identified trends with analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	DADS Policy #003 was reviewed and found to consistent with the Settlement Agreement. ABSSLC had not adopted the State policy in its totality as it had the policies for A/N/E and Incident Management. While the SSLCs must adhere to the requirements of State policy, they had not been required to adopt them in total. However, adopting them would be one way of assuring there was no confusion among staff with regard to what is expected. Following that adoption with a series of Facility procedures would be one way to assure that staff understand how policies and procedures were linked together. According to the POI by June of 2010, facility specific policy was to be revised to include the Corrective Action Plans and Monitoring processes in addition to regulatory compliance. At the time of the review, this policy was reported to be in draft and not ready for distribution. Data was available on abuse, neglect and incident management, unusual incidents, and restraints by program area, living unit, shift, and area of care (living room, bathroom, etc.), but not yet by individual and staff member. According to Facility staff, producing data by individual and by staff member implies the use of names that runs afoul of privacy and personnel protections. These will need to be resolved to provide meaningful trend data in these areas.	Noncompliance

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		The data was available and trended in user-friendly charts and graphs on monthly and quarterly bases. For example, there were monthly trend reports on injuries, abuse/neglect/exploitation, incidents, and restraints with trend analyses on a quarterly basis that highlighted important factors resulting from the analyses. These data provided a rich resource for following trends facility-wide and by individual unit. ABSSLC had made considerable headway in making these data available by program units and by residences. Additional data will emerge from the use of the monitoring tools to assess compliance with the Settlement Agreement. The use of these tools by Program Compliance Monitors was just getting underway and systems for managing the resulting data were under discussion according to the Settlement Agreement Coordinator. In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had begun to collect some data, for example, data related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. For example, data needs to be incorporated into the system regarding at-risk individuals; medical, psychiatric, and nursing issues, infection control, physical and nutritional supports, skill acquisition and day/vocational activities, behavioral supports, and outcomes for individuals related to transition to the most integrated setting. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system. As noted above, quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, some modifications had been made to these tools, and they were being field-tested. It was positive that the Facility was making use of the tools developed by the Monitoring Teams. However, while on site, the Monitoring Team discussed with Facility staff some of the additional modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to:	

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		▪ The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. ▪ The items on the tools have not been weighted, but would need to be if they were going to be used to generate cumulative scores. ▪ Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators. ▪ At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. The Settlement Agreement Coordinator was monitoring provision E of the Settlement Agreement using the recently adopted monitoring tools. As of June 2010, that monitoring had not found all requirements of this element to be met. While this element is not in substantial compliance, significant progress has been made.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such	Facility policy and procedures had not been issued as of August 5, 2010 to cover the analysis of data and corrective action plans. A Quality Enhancement Plan had been revised as of 6/17/10 to establish some basic procedures for monitoring Settlement Agreement sections, collecting data from those monitoring activities, analyzing and trending the data. Since that amendment, the tools for monitoring have been adopted based on tools used by the DOJ Settlement Monitors. The Quality Enhancement Plan will	Noncompliance

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	plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	need to be further revised to reflect that change. The Quality Enhancement Plan included a process for developing Corrective Action Plans (CAPS) by program areas. Assignment of responsibilities was included in the plan. The Performance Improvement Council (PIC) was charged with discussing the status of improvements and making recommendations to modify CAPS as needed. A PIC meeting was observed during the monitoring visit. The meeting was well-run, participants were prepared to make presentations on their respective CAPS, and decisions were made about the next round of CAPS to undertake. The PIC appeared to be instrumental in moving the Quality Enhancement Plan forward. The pace set by PIC for developing the necessary processes was a measured one: fast enough to show real progress, but not so fast that it overwhelmed participants, potentially resulting in failure. As was discussed during the monitoring visit, particularly for complex CAPs, the Facility should consider focusing on making substantial changes in one residence or unit at a time. This would ensure that concentrated efforts could be devoted to the change process to ensure success. This would require prioritization of the need for changes to be made, particularly changes that impact the health and/or safety of individuals. It also would require planning to ensure that once the mechanisms for making the changes are established that there be expedient roll-out of the change process to other homes or units. While this element was not yet in substantial compliance due to the need for the analysis of additional information, and the development of CAPs to address identified issues, good progress had been made.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	As described in section E2, the Quality Enhancement Plan outlined the basic CAP process. Development of CAPS began by assigning one CAP per SA section. According to discussion at the PIC on August 2, 2010, most of these first CAPS had begun to be implemented. This process allowed those responsible an opportunity to work on one CAP to become familiar with the process. As these first CAPs were completed, a second round was to begin with each program area identifying additional CAPs to develop and implement. While significant progress had been made and the circle of people who were knowledgeable and experienced in implementing CAPS had widened, this was the beginning stage of the process and had not yet developed to a point where CAPS could be distributed to all responsible entities to address all identified issues, nor was there a tracking system in place to efficiently monitor progress. As a result, this element was not in substantial compliance.	Noncompliance

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E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The procedure for monitoring of the CAPS was outlined in the Quality Enhancement Plan. According to the Plan, the CAPS would be tracked on a CAP Tracking tool to monitor status of improvement. Departmental monitors and QE Program Compliance Monitors would monitor the program areas to provide the data to track improvement. An opinion on whether this process will be effective awaits the development of the tracking tool and some analysis of results of what is already underway. As noted in the POI, this element was still under development and was not yet in substantial compliance.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The Quality Enhancement Plan indicated that the PIC would discuss the status of improvements and recommend modifications to CAPS that were not working. This suggested that the PIC and its members understood that a CAP was only as good as the results it attained. This will continue to be assessed as CAPs are developed and assessed.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. As is detailed above with regard to Section E.1 of the SA, the SA monitoring tools should continue to be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate.
2. The Facility should develop and implement a tracking system that allows identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.
3. As recommended in the previous report, data currently being collected and analyzed should continue to be used to identify areas in which improvements are needed. These data should continue to be used to identify problematic trends and/or individual issues, and the Facility should develop, implement, and monitor corrective action plans to address them.
4. At the time of this most recent review, the Facility had developed a CAP and had begun to monitor progress in response to individual-to-individual aggression that was identified in the last report submitted by the Monitoring Team. Such aggression often resulted in injury and required immediate attention. The Facility should continue to monitor the CAP to ensure that it results in changes in the outcomes for the individuals served.
5. The issue of how to trend data by employee and by individual should be resolved by developing a coding system that protects the confidentiality of individuals and staff, but also allows for adequate trending, analysis, and corrective action to be taken.
6. As particularly complex corrective action plans are developed, the Facility should consider focusing on making substantial changes in one residence or unit at a time. This would ensure that concentrated efforts could be devoted to the change process to ensure success. This would require prioritization of the need for changes to be made, particularly changes that impact the health and/or safety of individuals. It also would

require planning to ensure that once the mechanisms for making the changes are established that there be expedient roll-out of the change process to other homes or units.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments, and Supports), 7/30/10 o ABSSLC Plan of Improvement for Section F, dated 5/17/10; o ABSSLC Supplemental Plan of Improvement for Section F, dated 5/17/10; o Personal Support Plan (PSP) Meeting Dates; o List of Admissions within the last six months; o Personal Support Plans, and related assessments for: Individual #505, Individual #310, Individual #79, Individual #443, Individual #540, Individual #399, Individual #111, Individual #538, Individual #49, Individual #486, Individual #481, Individual #218, Individual #272, Individual #167, Individual #243, Individual #455, Individual #278, Individual #230, Individual #4, Individual #481, Individual #341, Individual #447, and Individual #534 ▪ **Interviews with**: o Juan Herrera, Qualified Mental Retardation Professional (QMRP) Coordinator; o Five QMRPs involved in the PSP Pilot Project, including Kristin Wyrick, Kelli Garret, Yvonne Chambers, Haley Savage, and Candice Wilkins; o Various staff in residences and attending PST meetings; and o Sam St. Clair, Director of Quality Enhancement ▪ **Observations of**: o Annual Personal Support Team (PST) meeting for Individual #7, on 8/3/10; o Annual PST meeting for Individual #391, on 8/5/10; o Annual PSP meeting, on 8/4/10; and o Activities in homes and day programs
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although it could not be determined how the Facility had reached its conclusions with regard to compliance findings, the Facility's POI for Integrated Protections, Services, Treatments and Supports was appropriately conservative in its ratings of compliance. The Facility indicated it was in compliance with Section F.1, and some indicators with regard to other requirements of Section F, such as attendance of the QMRP at the meetings, development of a PSP for each individual, and identification of data collection methodologies for strategies included in PSPs. As is illustrated below, the Monitoring Team did not substantiate most of these compliance findings. For example, as is discussed in many sections of this report, such as with regard to the provision of psychiatric care, nursing care, and physical and nutritional supports, PSPs did not define adequate data collection methodologies for programs and plans that should have been implemented into individuals' PSPs. As is described below with regard to Section F.2.g of the SA, the Facility appeared to be in the initial stages

	of refining the tools and developing the processes to complete a thorough self-assessment with regard to Section F. The Facility had adopted the Monitoring Teams' tools, and the Facility had begun to customize them to meet its needs. This process needed to continue, and there needed to be additional training for staff responsible for the audits, implementation of an inter-rater reliability system, and processes developed and implemented to allow aggregation and analysis of the data. All of these activities were necessary to allow the collection and analysis of the data in a meaningful way that resulted in the identification of issues requiring attention, and the development and implementation of corrective action plans to address potential causes of issues identified.
	Summary of Monitor's Assessment: While this Section of the Settlement Agreement is complex and will continue to require the collaboration of all disciplines, there had been progress since the baseline review was conducted. Specifically: ▪ The DADS policy was issued at the end of July; and ▪ ABSSLC had piloted a new format of the PSP. Five QMRPs had been working with the pilot versions of the new PSP, sharing challenges, offering suggestions for improvements, and generating PSPs in a new way. Staff who had been involved in the pilot project were excited about the expansion of participation of individuals, families, and direct support professionals. They reported that the revised process helped to identify what individuals preferred, and what their goals were, and then assessment information was used to assist the team in developing a plan that was more person-centered. The process reportedly focused more on individuals' strengths, and built support and service configurations around the person to support him/her in achieving desired goals. Some areas that required attention included: ▪ As is noted in many sections of this reports, comprehensive, thorough and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, Structured Functional Assessments, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning; ▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen; and ▪ Even with the newly formatted plans, not all plans such as behavior support plans, physical and nutritional management plans, nursing plans, etc. were fully integrated into the plans.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual	The DADS policy for this section was issued on 7/30/10. Comments on sections of the policy have been included as they relate to the provisions of the Settlement Agreement. ABSSLC had not issued a companion policy as of the monitoring visit. ABSSLC had piloted a new format of the PSP. Five QMRPs had been working with the	

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	shall:	pilot versions of the new PSP, sharing challenges, offering suggestions for improvements, and generating PSPs in a new way. Staff who had been involved in the pilot project were excited about the expansion of participation of individuals, families, and direct support professionals. They reported that the revised process helped to identify what individuals preferred, and what their goals were, and then assessment information was used to assist the team in developing a plan that was more person-centered. The process reportedly focused more on individuals' strengths, and built support and service configurations around the person to support him/her in achieving desired goals.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	DADS Policy #004 at II.C.1.b indicated that the QMRP would plan and facilitate the PSP meeting. The QMRP Coordinator confirmed that a QMRP or a Nurse Case Manager was assigned to each individual, but indicated that in meetings where there was another more senior team member or someone who knew the individual very well, that person might facilitate the meeting. During the on-site visit, members of the Monitoring Team attended the PSP annual meetings for Individual #7, Individual #391, and Individual #337: ▪ During the annual planning meeting for Individual #7, the QMRP facilitated the meeting. ▪ In the meeting for Individual #391, the QMRP facilitated the meeting, and the Nurse Case Manager was present. ▪ Individual #337's meeting was facilitated by the QMRP. Although the QMRP was new in her role, she did a good job of eliciting information from team members, and attempting to integrate the various team members' information. For example, the team discussed the individual's behavior of stripping in public. Various team members provided input into possible functions of the behavior, and potential solutions. The team asked for an additional assessment to be completed with regard to swimming, because the team did not feel like it had adequate information to make recommendations in this regard. Generally, the facilitation of this meeting went well. However, an example of a missed opportunity was with regard to Individual #337's prescription of psychotropic medication. According to information provided by the psychology department, his behavior of self-injurious behavior had decreased to zero over the last nine months. The behavior therapist reported, though, that she could not remove the criteria for self-injurious behavior all together "because of the prescription of Zyprexa." The nurse had reported that his Zyprexa had been decreased in November 2009. Unfortunately, other than nursing, no other medical or psychiatric staff were present. The team did not pursue this issue, by, for	Noncompliance

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		example, requesting further information from psychiatry regarding the expected medication course, criteria that should be included in his Behavior Support Plan, etc. Likewise, his day activities appeared limited, but the team did not engage in discussions about how to increase such participation, particularly with regard to the many preferences the team had identified at the beginning of the meeting. It was a positive development that the new DADS policy was in place, and it was anticipated that in the early fall training would be provided to key Facility staff who would be responsible for providing additional training to others at ABSSLC. This policy clearly identified QMRPs as responsible for facilitating the teams. At ABSSLC, it appeared that QMRPs or Nurse Case Managers had been assigned to facilitate individuals' teams. However, based on review of PSPs, facilitation of team meetings was not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Personal Support Team (PST) to include the individual, the LAR, if any, the QMRP, direct support professionals, and persons identified in the Personal Focus Meeting as appropriate, as well as professionals dictated by the individual's strengths, needs and preferences. The team membership sign-off sheet was not available for all plans reviewed. According to discussions with the QMRP Coordinator, the anticipated changes to the PSP included provisions to automate the list of planning team participants, so that it would be possible to track team participation. In the pilot PSPs, the new forms for signatures were in use and included check boxes to indicate whether participation was full or partial. The forms appeared to be able to be customized to include the team members expected to participate. In the five pilot plans (Individual# 49, Individual #486, Individual #111, Individual #538 and Individual #481) those attending annual planning meetings included: ▪ The individual attended two meetings (40%); ▪ The QMRP and the nurse were at every meeting (100%); ▪ The psychologist was at four meetings (80%); ▪ The LAR was at two meetings (40%); ▪ Direct support professionals were at three meetings (60%); and ▪ Vocational services attended two meetings (40%). There were others in attendance at the meetings including speech therapists, habilitation technicians, and home supervisors as were needed to prepare the plans. What was not clear was whether the list of possible participants was the list of people who should have attended. Once that is established, it should be possible to ascertain whether meetings	Noncompliance

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		include the necessary participants. As is noted in other sections of this report, members of teams who should have been at individuals' meetings did not consistently attend, resulting in teams not having adequate information and expertise to make decisions. For example, as is discussed below with regard to Sections O, P, and R of the Settlement Agreement, therapists were not present consistently at meetings for individuals who had physical and nutritional support needs, and/or communication needs. This often resulted in the supports in these areas not being adequately integrated throughout the plan, and implemented throughout the individual's 24-hour day. In reviewing individuals PSPs, at times there were issues requiring the attendance of specific team members, but these team members were not in attendance. For example: ▪ Individual #481's team discussed his work, and that he might be a good candidate for a recycling job. However, his "Vocational Services Case Manager was unable to attend his PSP." The Facility POI did not find this element to be in compliance, which is consistent with the Monitoring Team's assessment. However, the pilot PSP process represented good progress and a corrective action plan had been initiated to help ensure that teams are duly constituted.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve their goals, and overcome obstacles to community integration. Most of the PSPs reviewed contained assessments of health, residential living [often Positive Adaptive Living Skills (PALS)], behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, vocational or day evaluations, and other assessments based on specific needs. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further details throughout this report with regard to the sections of the Settlement Agreement that address psychiatric services (Section J), psychology (Section K), medical services (Section L), nursing services (Section M), physical and nutritional supports and OT/PT (Sections O and P), communication (Section R), and habilitation and skill acquisition (Section S). In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs.	Noncompliance

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		The vocational assessment format being utilized did not adequately address individuals' strengths, needs and preferences. The current "Vocational Services Evaluation" form consisted of a brief questionnaire that included information related to an individual's work schedule, abilities and achievements, and recommendations. It was unclear what training was provided to staff responsible for completing vocational assessments, but the form lent itself to a rather subjective and surface review of an individual's vocational strengths and needs. It did not create a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory. For example: ▪ Individual #481's vocational evaluation, dated 6/2/10, merely listed three abilities/achievements, including making choices, demonstrating knowledge of laundry tasks, and being productive for short periods of time. The recommendation section indicated that he left the work area several times a shift, and little progress had been noted on his current objective addressing this, so, a verbal prompt was to be added. This individual's PSP indicated work was important to him, but this evaluation gave his team little information with which to develop goals and objectives to identify meaningful work opportunities, and assist Individual #481 in being as independent as possible in a work setting. ▪ Similarly, Individual #341's vocational evaluation, dated 4/22/10, included minimal information. It appeared to be based on anecdotal or subjective information, as opposed to interest inventories, or, more importantly, situational assessments. Other than her current job in an on-campus workshop, it provided no information regarding work history. One assessment that would prove useful for some individuals would be an annual review of incidents, and A/N/E allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. This was an area that during interview, the QMRP Coordinator and five QMRPs who participated in the pilot project recognized as an area that needed improvement, if the new PSP process was going to be successful. This is consistent with the Monitoring Team's findings.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	There was not always a clear connection between the assessments and the PSP. For example: ▪ Individual # 540 liked food and going for rides. However, she grabbed food including hot coffee, and was once burned doing so. One assessment indicated it was not safe to allow her to return her plate to the counter after dinner because she might grab something hot on the counter and burn herself. Meanwhile, her	Noncompliance

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		action plan called for trips to Starbucks (where hot coffee and other attractive foods are in easy reach.) ▪ Individual #218 had a recreation evaluation that indicated she participated and was interested in activities, but attendance was poor, without clarifying what was meant by "poor," or why she was not attending. This information was not helpful in designing the services and supports she needed. There appeared to be some progress in using assessments to develop and change the services and supports in the PSP, particularly in the plans using the pilot format. However, the pilot was still just beginning to produce results and training and practice will be required to assure that all staff charged with contributing to plan development are able to use assessment results in plan development. In addition, there appeared to be two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a PSP that outlined the protections, services and supports provided to the individual. These were: 1) as is noted above in the section of this report that addresses Section F.1.a of the SA, there was a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limited teams' ability to utilize assessment information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement	Noncompliance
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for		

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	each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	DADS Policy #004 at II.D.4 indicated that Action Plan should be based on prioritized preferences, strengths and needs. The use of the Personal Focus Worksheet appeared to be helping teams to better understand the preferences and strengths of individuals. However, clear prioritization of the individual's needs or careful delineation of barriers to addressing needs generally was not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. It was not consistently clear whether or how the goals and objectives were related to individuals' preferences, or were designed to overcome barriers to living in the most integrated setting. For example: ▪ Individual #272 had serious problems with pica, liked to walk, play basketball and listen to gospel music. His Action Plans included sensory stimulation, visits from family, health, hygiene and being independent in money and phone usage. It was not clear how his team had decided on these action plans based on his prioritized needs. ▪ Individual #447 had a list of nine training objectives that were listed under Action Plan #2 that was designed to "increase her interaction and communication with others." These training objectives related to issues such as bathing, anger management, purchasing a snack, and exercise. In addition to it being unclear how the items on this list had been prioritized from her list of need areas, it also was noted that under Action Plan #3, one of the items was to "continue excellent leisure time with staff and select peers." It appeared from this that Individual #447 already had skills with regard to interacting and communicating with others. A member of the Monitoring Team met Individual #447 during the baseline review, and witnessed her significant abilities to interact with others, including people she did not know. ▪ Individual #447's PSP indicated she was at Medium Risk for weight. The only skill acquisition goal related to this included an exercise program. Despite this individual's higher cognitive skills and the fact that social activities were identified as a preference, there was no evidence that the team considered a diet group, such as Weight Watchers. Interestingly, one of her other goal programs was for purchasing a snack, but the instructions for this goal did not include providing any education about healthy snack choices, or offering such choices.	Noncompliance

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		Some of the pilot PSPs offered better opportunities for making connections and prioritizing, because some of them prefaced each Action Plan with discussion across disciplines. However, this was not consistent. For example: ▪ With Individual #538, it was not clear whether community placement was the first priority because it came first in the plan, or whether continued relationships was more important, or how both could be achieved. The ability to prioritize needs and explain barriers might be enhanced as teams try to understand what "desired outcomes" are at the beginning of each Action Plan. If "desired outcomes" were designed to be individualized (to have a pet cat) rather than generic (to maintain relationships), perhaps it would be easier to assign priorities.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	As noted in the baseline report, PSPs generally had some individualized and measurable goals/objectives, treatment strategies and supports. However, none of the plans reviewed included a comprehensive set of measurable goals, objectives, treatments and strategies to be employed to fully support the individual. As is discussed in other sections of this report, nursing plans, Behavior Support Plans, and physical and nutritional support plans were not fully integrated into the PSP. They were generally stand-alone documents that may have been referenced in the PSP. Specific individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of these essential plans. For example, in order to provide health care supports to individuals served, direct support professionals (DSPs) as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. Moreover, these plans (e.g., BSPs, PNMPs, etc.) often did not include goals and objectives that were measurable. These specific concerns are detailed below with regard to Sections K, M, O, P and R of the SA.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As reported in the baseline review, while some protections, services and supports, treatment plans and clinical care plans were integrated into the plan, others such as behavior support plans, physical and nutritional support plans, and nursing care plans stood apart. This continued to be true for most plans. The pilot PSPS had moved farther into the integration of services and supports by encouraging cross-discipline discussion as part of designing Action Plans. However, the Action Plans that were developed did not consistently integrate all of the services into a comprehensive plan. For example: ▪ Individual #538 had a PNMP that was not integrated into the Action Plans. Moreover, such a plan should have been integrated with other supports, such as	Noncompliance

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		nursing care plans related to medication management. Likewise, Individual #538 had nursing care plans for seizures, alteration of skin integrity, osteoporosis, and hypothermia. Her Action Plan related to health indicated that the RN and QMRP would monitor these monthly. This did not demonstrate an integrated approach to planning. Such plans should be integrated throughout the document and her 24-hour day. In addition to the nurse and the QMRP, direct support professionals, as well as therapists, etc. need to be responsible for components of these plans.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	DADS Policy # 004.II.D.4.d included the required elements. Generally, for the action items identified by teams, methods, timeframes and staff responsible were identified. However, methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As is identified in other sections of this report, not all of the interventions, strategies and supports offered to individuals at ABSSLC effectively addressed individuals' needs, and not all were practical and functional at the Facility and/or in community settings. Again, these are discussed with regard to the need for improvements with regard to plans to address conditions that place individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and Behavior Support Plans.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection and provided for monitoring of the plan. Generally PSPs specified data to be collected and/or documentation to be maintained and specify a frequency for collection. It was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes to the process when there was little or no progress. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet in place to determine the reliability of the data. There were some indications that the data being collected was not reliable. One of the investigation reports reviewed in relation to Section D of the SA also identified significant concerns regarding the data reliability. It was not clear that the data collected was accurate, and/or that changes were being made to plans based on the collected data and as a result.	Noncompliance

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F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted above, there were issues with regard to the integration and coordination of outcomes, services and supports in individuals' PSPs. This will continue to be evaluated as the new policy and format for PSPs is implemented. The POI pointed to the PSP pilot as a means for improving the coordination of the various elements within the PSP. The format did encourage coordination by requiring discussion across disciplines for each action plan. However, it will require good facilitation training for staff, particularly QMRPs to realize that coordination.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	DADS Policy #004.II.D.m required the PSP to be accessible and comprehensible to staff who must implement it. PSPs were located in the residences in locked cabinets for security reasons. Given privacy and security considerations this was appropriate. A key appeared to be available to staff when there was a need to see the plan. The pilot PSPs provided a more interesting narrative that explained more of the background for decisions and provided a more person-centered focus on the individual. However, the level of narrative included in the new format PSPs could prove challenging to some staff members. Plain language instruction in abbreviated form may be needed to make PSPs comprehensible. It was early in the process of adjusting to the new policy and the pilot PSP was not out of its development stage, but these steps represented real progress toward developing a more meaningful PSP.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has	DADS Policy #004 at III addressed personal support plan monitoring including the requirements of the SA. Copies of monthly/quarterly review documentation and PSP addendums were requested as part of the document request for the following six individuals: Individual #411, Individual #243, Individual #447, Individual #357, Individual #341, and Individual #102. No documentation was provided of any monthly or quarterly reviews.	Noncompliance

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	occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.		
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	DADS Policy #004.IV addressed staff training on the PSP process that comports with the SA requirements. As noted previously, it was anticipated that key staff from ABSSLC would attend training during the fall on the new policy and PSP format, and they would be responsible for training other ABSSLC staff. One of the QMRPs who had participated in the pilot project was involved in filming a training video. One of the components of the video was aimed at training meeting facilitators how to address "bad behavior" at meetings, such as leaving early, or reading directly from the assessments. These is the type of training that should provide QMRPs with tools with which to achieve better interdisciplinary team process. As noted in the baseline report, the Monitoring Team reviewed training materials that had been developed in 9/09 regarding the PSP process. A number of both positive and negative aspects of this training were noted. These will not be repeated here. However, at the time of this most recent review, this was the most recent training that had been provided on PSPs, and it was not adequate. The Monitoring Team looks forward to reviewing the new training, including the competency-based evaluation components.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a	A review of the listing of meeting dates for PSPs for individual who required an annual review revealed that of 445 PSPs, 432 (97%) were timely. Those for whom annual reviews had been late included: Individual #328, Individual #480, Individual #489, Individual #76, Individual #269, Individual #24, Individual #405, Individual #149, Individual #159, Individual #94, Individual #160, Individual #146, and Individual #325. Information provided by ABSSLC indicated there were seven new admissions between January and June 2010. Of the seven, two were in the PSP sample drawn for review. Both of them, Individual #79 and Individual #455, had had PSPs developed within the 30-day timeframe for new admissions. What could not be determined was whether the PSPs went into effect within 30 days. At	Noncompliance

#	Provision	Assessment of Status	Compliance
	written extension.	the time of the review, the Facility had no way of tracking this. Discussions with staff indicated that the expectation was that the plan would be finalized within 30 days of the meeting, and filed in the active record to allow timely implementation.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	DADS Policy #004.V addressed quality assurance processes to ensure PSPs are developed and implemented consistent with the provisions of the SA. The Quality Enhancement Unit had activity underway to assure that PSPs were being developed and implemented consistent with the SA. Monitoring tools had been adopted, and were being modified for Facility use as described in Section E of this report. Field tests of the tools were underway.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, particularly as is relates to the interdisciplinary team process.
2. As teams are trained on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
3. As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs.
4. Alternatives to the current vocational assessment tool should be considered.
5. Consideration should be given to adding to the PSP process an annual review of incidents, and A/N/E allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise.
6. The Facility's QE processes with regard to PSPs should include reviews to ensure that all of the components of the Settlement Agreement with regard to PSPs are addressed, including but not limited to assessment to ensure that:
    a. Team composition includes the individual, the LAR, the QMRP, staff who regularly provide direct supports to the individual including vocational staff and others that reflect the individual's preferences, needs and strengths;
    b. Comprehensive assessments are completed, and the results integrated into the PSP;
    c. Assessments are completed to identify the preferences of the individual and his/her LAR, and that this information is used meaningfully by the team in developing supports and services for the individual. Teams should constantly challenge themselves to discover creative ways to deliver what is needed in ways that are positive for the individual, and help move her/him farther toward her/his goals.
    d. Team meetings include interdisciplinary discussion that utilizes the team's knowledge of the individual and his/her strengths, preferences, desired outcomes and needs to develop one comprehensive, integrated plan for each individual.
    e. Interventions, strategies and supports are functional at the Facility and in the community.
    f. Community integration is encouraged.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Psychotropic Polypharmacy Review Committee meeting minutes, dated 5/3/10, 6/15/10, and 7/5/10; o PCP notes concerning consultant recommendations for the following individuals: Individual #325 for 7/29/10 cardiology consultation; Individual #325 for 7/29/10 psychiatry consultation; Individual #201 for 7/26/10 psychiatry consultation; Individual #454 for 7/26/10 psychiatry consultation; Individual #330 for 7/27/10 cardiology consultation; Individual #254 for 7/27/10 neurology consultation; Individual #343 for 7/27/10 ophthalmology consultation; Individual #327 for 8/2/10 neurology consultation; Individual #238 for 8/2/10 neurology consultation; Individual #259 for 8/2/10 neurology consultation; Individual #377 for 8/2/10 neurology consultation; Individual #396 for 8/2/10 neurology consultation; Individual #130 for 8/2/10 neurology consultation; Individual #46 for 7/29/10 psychiatry consultation; Individual #22 for 7/29/10 psychiatry consultation; Individual #332 for 7/29/10 ophthalmology consultation; Individual #243 for 7/28/10 psychiatry consultation; Individual #159 for 7/29/10 psychiatry consultation; Individual #146 for 7/28/10 cardiology consultation; Individual #434 for 7/28/10 dermatology consultation; and Individual #322 for 8/3/10 ophthalmology consultation ▪ **Interviews with:** o Dr. Richard Chengson, Medical Director; o Marla Knight, Pharm D.; o Debbie Sessions, MS, CCC, Speech Language Pathologist (SLP) on Nutritional Management Team (NMT); o Nicole Spaulding, Registered Dietician (RD); o Tricia Reyes, Registered Dietician; and o Pat Johnson, RN on NMT ▪ **Observations of:** o Nutritional Management Team meeting, on 8/4/10
	Facility Self-Assessment: The Facility was in the early stages of developing integrated clinical services. There were some interdisciplinary meetings or activities occurring to ensure that clinical services were integrated to meet the needs of the individuals, such as a Psychotropic Polypharmacy Review Committee, and a nurse liaison to the hospital reporting back to the Facility. However, as reflected in the Facility's self-assessment, the Facility recognized they were not in compliance with the requirements of this section of the Settlement Agreement.
	Summary of Monitor's Assessment: There had been progress made in developing integrated clinical

	services, especially with the psychiatric consultants and the primary care practitioners (PCPs), as well as the important step of providing a nurse liaison to the hospital. However, there was a significant need to look globally at the requirements in this section of the SA. One important step would be to develop a daily morning meeting to review all significant healthcare concerns from the prior 24 hours (72 hours for a Monday meeting). Such meetings should include the Medical Director, all primary care practitioners, the Chief Nurse Executive (CNE) or delegate, and members of other departments as needed, such as a psychologist, or lead QMRP. The meetings should involve reviewing each individual's case or significant concern as a team. This also would provide the first step in guiding the at-risk process, because most risk issues concern health issues, and such a meeting would allow the health care team to provide guidance. If this team were to review the health issues of the entire campus each day, it would provide a standardization of risk assessment, and provide an immediacy to the risk assessment that was not available at the time of the review. The NMT was composed of staff with full-time duties in their own departments. As required by the Settlement Agreement, the creation of a Physical and Nutritional Management Team (PNMT) that is dedicated to dysphagia and dining concerns is essential at ABSSLC, as 60 percent of deaths in the recent months had been caused by or associated with pulmonary problems. One of their important roles would be training and teaching all departments about dysphagia. As individuals with seizures move to the community, collaboration will need to be heightened between families and community providers and the medical staff. Diastat is a medication frequently used in the community to treat prolonged seizures, and usage at ABSSLC as a transition medication to determine efficacy, as well as to teach the receiving providers would assist in quality transition to the community. Unfortunately, Diastat is not on the State Formulary. Physicians had recently begun to dictate and document agreement with consultant recommendations, but there needs to be a system to ensure all consultant reports are received and recorded, as well as reviewed to ensure compliance.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals	The Medical Director stated that ABSSLC had a nurse who was a liaison to the hospital. The nurse travelled to the local hospital daily to determine the status of anyone who had been admitted from ABSSLC. Then the nurse returned and created a typed progress note in the medical record of that individual. This allowed the Medical Department and nursing department to work together to prepare for the return of the individual. These two departments had information necessary to know and understand the needs of the individual as he/she returned, and would be able to take steps to provide a smooth transition back to ABSSLC. It also provided an added avenue of communication to and from the hospital.	Noncompliance

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	receive the clinical services they need.	However, there was lacking a daily forum for the health care disciplines to review all significant health concerns of the prior 24 hours (or 72 hours for Monday meetings after a weekend). Such meetings would provide an excellent place to share expertise between disciplines, and to provide guidance to the PST on health care issues. Such meetings should include the Medical Director, all primary care practitioners, the Chief Nurse Executive (CNE) or delegate, and members of other departments as needed, such as a psychologist, or lead QMRP. It also would have other synchronous tasks, such as alerting the PCPs to ongoing issues for which they might be called to assist when on-call, as well as a forum to discuss at-risk issues and provide guidance to individuals' PSTs (this aspect is discussed with regard to Section I of the SA). Holding such meetings would be an important step in developing integrated clinical services. The Psychotropic Polypharmacy Review Committee was a forum in which the disciplines of primary care, psychiatry, pharmacy, nursing, psychology, QMRP, and direct support professionals met to discuss individuals with challenging psychological and psychiatric issues. When possible, there was the goal of simplification of drug regimen and reduction of medications. This was an excellent forum for problematic cases, but the in-depth discussion and problem solving limited the ability to review all individuals on polypharmacy. Such meetings should continue to be encouraged, especially for those at highest risk of adverse effects from polypharmacy, or polypharmacy that was not associated with improvement in behavioral, psychiatric, or medical goals. It is recommended the committee identify those individuals who would benefit from such an in-depth interdisciplinary approach and once the backlog has been identified, meet more frequently, if indicated, to review these cases over the next quarter. The Committee then could be dedicated to reviewing new cases and in monitoring those already reviewed by the committee for progress. There also should be a tracking mechanism to ensure the ideas and steps agreed upon at the Committee are accomplished and progress reports are included in future meetings. The psychiatry services were integrated with psychological services in that the Psychologists had an integral role in the Psychiatric Clinic process. The Psychiatric Clinics were the primary forum for coordinating that aspect of the medical care for the individuals who resided at the ABSSLC. The Psychologists were responsible for providing the data that influenced and affected the decision-making of the Psychiatrist. However, the review of the individual records described in Section J revealed that the behaviors that were described in the Functional Analysis and Behavior Support Plan as being present on a behavioral basis were also frequently described in the Psychiatric section as "targets" for the psychotropic medication. This would suggest that either the psychotropic medications were being used to suppress behaviors related to environmental and interpersonal factors, and/or there was a lack of integration between the Psychiatry and Psychology Departments in the development of these plans.	

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		The integration between Psychiatry and Medicine was primarily represented by the participation of the Nursing Staff in the Psychiatric Clinic process, as well as the *MOSES/DISCUS* monitoring for side effects. The interaction between the Psychiatrists and the Primary Care Practitioners was usually accomplished by written consultations between disciplines, as well as telephone contacts. The Consulting Psychiatrist indicated that Medicine does not routinely consult with Psychiatry concerning the development of pre-treatment sedation protocols for medical appointments, unless the protocols that were commonly utilized were ineffective. The interaction between Pharmacy and Psychiatry was primarily in the form of the detailed Quarterly Reviews of the psychotropic medications that the Pharm. D. prepared. In addition, the Pharmacy entered every new medication order through a software system that checked for potential interactions and notified the prescriber if there was an issue with the medication. The Psychiatrist would be notified if this occurred with a newly prescribed psychotropic medication. The Facility had recently adopted the use of a new format for the Quarterly Drug Regimen Reviews. This form included a signature line to indicate that the Psychiatrist had reviewed it. This should facilitate the documentation of the interaction between the two disciplines in the future. As individuals transition to the community, the medical staff need to consider how to ensure the quality and continuity of care, and to ensure that an integrated approach is used in assisting individuals who are transitioning. ABSSLC had a high number of individuals with seizure disorders considered difficult to control. At the time of the review, when there was a prolonged seizure or status epilepticus, parenteral Ativan was administered. In the community, there would not necessarily be the nursing availability to administer this medication. Diastat has been safely and effectively administered by families or staff trained in medication administration for many years, and consideration should be given to changing these individuals to this medication before they transition to the community to determine effectiveness. In order for individuals with seizure disorders not to be delayed from transitioning, part of the transition process would need to be to teach the receiving families the administration of Diastat or ensure the availability of trained staff. It is recommended that the Medical Director collaborate with the neurology consultant to review this possibility. Diastat also has been safely and effectively used in the large facility settings, and avoids the potential for a needle stick injury as an additional benefit compared with parenteral Ativan. It also is preloaded to the correct amount, which reduces the possibility of error in drawing up the wrong amount. The Nutrition Management Team was not a dedicated team on campus. It was composed of a speech language therapist/pathologist, two dieticians, and a nurse. Each had their	

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		own caseload in their own disciplines. The members of the NMT were under the organizational umbrella of the rehabilitation services department. At the time of the review, there were an average of four to eight significant coughing or choking episodes a month to which the NMT was called for an evaluation. At that time, occupational therapy or speech therapy would complete a mealtime assessment with recommendations for changes in equipment or food textures. A second episode was usually followed by a recommendation to the physician for a modified barium swallow study (MBSS). An incident requiring use of the Abdominal Thrust became an immediate serious incident investigated by the OT and SLP. For these individuals, there might have been an emergency texture change and/or supervision change not requiring physician involvement until a full eating assessment could be completed. The NMT conducted a record review, and provided monitoring and follow-up through this process. The speech therapist had an excellent rapport with the local hospital that conducted the MBSSs. Food with differing textures was taken from the kitchen at ABSSLC and used for testing during the study. Positioning was also done. There were several textures offered, labeled as follows: thin, tomato juice, nectar, honey, milkshake (pudding) and "thicksticky." ABSSLC recently had been in the process of transferring the responsibility of thickening liquids from staff to a system of ordering pre-thickened products. The NMT meetings were held weekly and discussed between 14 and 23 individuals at one time. There was currently little collaborative interaction between members of the NMT and the medical staff. In the past, there was resistance from physicians to follow the recommendations of the NMT, and this had had varied improvement over time. Based on chart review of individuals who have been hospitalized for acute illness, many due to aspiration pneumonia, the medication administration observations and interviews with the nursing staff, there was little to no collaboration between nursing and the PNMT regarding the individuals who have recurrent pneumonias and aspiration pneumonias. Nurses were not assessing safe positioning for individuals when they received medications via orally or enterally. In addition, nurses were not checking the PMNPs prior to administering medications, and many plans were not kept in the Medication Administration Records (MARs). During the on-site review, the Monitoring Team met with members of the medical, as well as rehabilitation therapies group during which it was recommended that a dedicated team of professionals be assigned to the PNMT, as there was great urgent need in this area. Of the last 10 deaths, six were related to respiratory issues. These were often associated with or exacerbated and complicated by dysphagia, GERD, and aspiration. The evaluations and monitoring by a PNMT would be valuable to the	

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		individuals and to the medical staff. Having a medical staff member assigned as consultant to the team, or co-directing the team, would be beneficial in the start up of the team. These are complicated clinical issues that need cooperation and resources from many disciplines in order to be successful and have a positive impact on the health of the individuals at ABSSLC. Such a team would be especially valuable in the Infirmary to assess and recommend dining plan changes, and to mentor and teach staff in all departments. A review of the medical emergency drills found that there was no collaboration between disciplines for reviewing the Facility's medical emergency systems. The various specialty disciplines would have valuable input to offer for a system that is essential for the safety and wellbeing of individuals at ABSSLC.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	Recently, the medical staff had been writing notes, or dictating notes for transcription that were then placed in the record, for the purpose of documenting their review of the recommendations from the community consultants. This was to include a statement as to whether they were following the recommendations or not. Notes were reviewed for the following individuals: Individual #325 for 7/29/10 cardiology consultation; Individual #325 for 7/29/10 psychiatry consultation; Individual #201 for 7/26/10 psychiatry consultation; Individual #454 for 7/26/10 psychiatry consultation; Individual #330 for 7/27/10 cardiology consultation; Individual #254 for 7/27/10 neurology consultation; Individual #343 for 7/27/10 ophthalmology consultation; Individual #327 for 8/2/10 neurology consultation; Individual #238 for 8/2/10 neurology consultation; Individual #259 for 8/2/10 neurology consultation; Individual #377 for 8/2/10 neurology consultation; Individual #396 for 8/2/10 neurology consultation; Individual #130 for 8/2/10 neurology consultation; Individual #46 for 7/29/10 psychiatry consultation; Individual #22 for 7/29/10 psychiatry consultation; Individual #332 for 7/29/10 ophthalmology consultation; Individual #243 for 7/28/10 psychiatry consultation; Individual #159 for 7/29/10 psychiatry consultation; Individual #146 for 7/28/10 cardiology consultation; Individual #434 for 7/28/10 dermatology consultation; and Individual #322 for 8/3/10 ophthalmology consultation. The PCP agreed with all recommendations (100% agreement). Based on a review of these most recent transcriptions, this was a new and welcome addition to the system. However, it was not clear which consultation reports were being transcribed, or if all reports are or will be processed in this manner. The Facility had no tracking system in place to ensure that there was adequate review of consultants' recommendations. To ensure that the PCPs are processing all consultant reports, it is recommended that a log or roster of all consultant requests be developed, with date of order, date of consultation, and date primary care practitioner reviewed them. This	Noncompliance

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		would allow an internal QI review of the Medical Department concerning this SA requirement. Once the data provides evidence all consultant recommendations are reviewed, and either accepted and referred to the PST for discussion and implementation or an adequate justification for not implementing the recommendation, Section G2 will be considered fulfilled. The only routine involvement between Psychiatry and a non-facility physician would be with Neurology. The communication between the Psychiatry and Neurology Departments was accomplished through written consultations. As noted in Section J, documentation that the Psychiatrist had reviewed these notes could not be identified in the Neurology section of the sample of medical records that was selected for review.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. A daily meeting should be held (each weekday) that is interdisciplinary in nature and reviews all the significant health concerns that have occurred on campus within the prior 24 hours (72 hours for a Monday meeting). Such meetings would allow a sharing of expertise, and provide the first step into at-risk assessment and management process. They also would provide the needed information for the on-call PCP.
2. The Medical Director should discuss the use of Diastat with the neurology consultant to determine whether it should be included as an option in treating prolonged seizures at ABSSLC. As individuals transition to the community, for those with seizure disorders, utilizing Diastat instead of parenteral pro re nata (prn, or as needed) medications for seizure control would assist families and other providers in providing needed supports to these individuals. Providing Diastat as an option at ABSSLC would provide a trial run to ensure it was as effective as parenteral Ativan, and allow staff to train the accepting family or provider, adding further continuity to the transition process.
3. A dedicated full-time physical and nutritional management team should be created and empowered to focus on such issues as dining needs and dysphagia.
4. As part of their assigned tasks, it is recommended the PNMT spend about 25 percent of their time training and teaching other disciplines at ABSSLC concerning early warning signs of dysphagia, changes in diets, proper feeding techniques, and need for further evaluation, etc. This training and teaching should be available to all disciplines.
5. The Medical Director should be a participating member or a co-director of the PNMT.
6. The Medical Director should ensure all primary care practitioners cooperate with PNMT, and follow recommendations offered by the PNMT or document a rationale for not following recommendations in the integrated progress notes.
7. A tracking system for consultant reports should be developed that includes the date of the order, the date of the consultation, the date the report is received by the Facility, and the date the PCP reviews it.
8. The Psychotropic Polypharmacy Review Committee should identify those individuals who would benefit from the interdisciplinary approach used by the Committee, and meet more frequently to ensure completion of review during the next quarter of the year.
9. The Psychotropic Polypharmacy Review Committee should develop a monitoring system to ensure recommendations from the committee are tracked until completion, and the status of the implementation of recommendations is reported back to the Committee.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Medical records for Individual #100, Individual #511, Individual #208, Individual #294, Individual #431, Individual #281, Individual #10, Individual #317, and Individual #90; and o Medical records described in the section of this report that addresses Section J of the SA
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI acknowledged non-compliance for most of the indicators for Section H of the Settlement Agreement. This is consistent with the findings of the Monitoring Team.
	Summary of Monitor's Assessment: Documentation of annual reviews appeared to be adequate, as well the quality of acute medical care when an illness developed. However, the work-up of the illness in order to ensure it did not recur was sporadic or nonexistent in certain cases. The Medical Department needs to be proactive rather than reactive when treating illness. Rather than spending the majority of their time focused on acute illness needs, there should be a realignment of the department's goals to focus on how to prevent acute illness from occurring. There is a need for aggressive diagnosis and treatment when the health status of an individual changes. Critical clinical review of all repeat events, such as pneumonias, aspiration pneumonias, and serial vomiting, should lead to further evaluation and treatment, whether medical or surgical, until the issue is resolved. It is recommended that the Medical Director provide clear guidance as to the expected medical work-up and treatment with timelines for many conditions common to the Intellectual Disabilities/Developmental Disabilities (ID/DD) population. Standardization of care through clinical pathways would allow measurement of quality care, and would help to assure all individuals were treated according to these guidelines. With such a system in place, administration would be more confident that care was consistent and appropriately aggressive across the campus. The clinical pathways, when written with sufficient detail and guidance, also could be used as a source of clinical indicators and tools by which to measure quality improvement in the Medical Department, and quality of health for the individual.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular	Medical assessments were completed annually, and appeared to be up-to-date. As discussed with regard to Section L of the SA, for the records reviewed, there was compliance approaching 100 percent with completing the annual evaluation. In addition, acute care needs generally appeared to have been addressed appropriately and generally timely, once the physician was notified.	Noncompliance

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	basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	However, what was lacking or not well documented was the prevention of further occurrences of acute illness, especially when there were changes in an individual's status or condition. There was little to no evidence of critical thinking documented that would have been essential to timely detect and assess/evaluate evolving illnesses. For instance, Individual #100, Individual #511, Individual #208, Individual #294, Individual #431, Individual #281, Individual #10, and Individual # 317 all had worsening symptoms suggestive of progressive and worsening GERD, with aspiration, and respiratory compromise, but there was little evidence that signs and symptoms such as repeated vomiting, wheezing, bronchospasm, and repeated pneumonias were being evaluated from a preventive standpoint. This is discussed further with regard to Section L of the SA. There was evidence of current Psychiatric Assessments in 80 percent of the sample of individual records reviewed. There also was documentation that monthly interdisciplinary reviews of psychotropic medication were being carried out uniformly, as well as a quarterly direct observation of the individual by the Psychiatrist. However, the review of individual records described in Section J indicated that the quality of the documentation contained in the Psychiatry Assessments and the Psychiatry Clinic Reviews did not uniformly meet the standards set forth in the Settlement Agreement and Health Care Guidelines. The specific deficits included the lack of documentation regarding the identification of the specific symptoms that support the psychiatric diagnosis, the linkage between the psychiatric diagnosis and the "target behaviors" of the medication, and a clear empirical demonstration of efficacy.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses on both the active and inactive problem lists were based on the criteria of the International Classification of Disease. However, as mentioned above, there was concern for under diagnosis of critical illness that had the potential to lead to repeated morbidity and eventually mortality if accurate diagnosis and treatment did not occur. For example, Individual #90 expired under hospice care, but the record did not document an aggressive work up earlier in life, to discover diagnoses contributing to her downhill course, and based on findings, offered treatment options to reverse the downhill clinical course. The psychiatric diagnoses utilized at ABSSLC were consistent with the nomenclature utilized in the DSM-IV-TR. The current deficiency in this area was that there was incomplete documentation in the individual records, which set forth the specific symptoms that the individual presented in a manner that would support the validity of the psychiatric diagnosis.	Noncompliance
H3	Commencing within six months of	In order to standardized timely treatment and interventions, the Medical Director will	Noncompliance

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	the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	have to provide clear guidance as to the expected medical work-up and treatment with timelines in such common comorbid conditions as dysphagia, GERD, repeated pneumonias, fracture prevention, repeated vomiting, weight loss, constipation, pica, etc. The primary care providers need to understand what is acceptable and timely with regard to examination of the individual, in ordering tests, in providing treatment, the timeliness of further testing, and treatment options when there is another decline or continued signs and symptoms. The monthly Psychiatric Clinics and Quarterly Assessments of the individuals by the Psychiatrist were consistent with the requirements of the provision, in that they were performed in a "timely" manner. As noted above, and below with regard to Section J of the SA, the deficiencies regarding this provision relate to the requirement that these interventions be "clinically appropriate based upon assessments and diagnosis."	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	ABSSLC did not have a set of clinical indicators to measure the efficacy of treatments. In developing guidance for a number of medical issues, the Medical Director should provide sufficient details within the clinical pathways to allow identification of clinical indicators. For instance, if someone has an aspiration pneumonia, and the clinical pathway indicates that an aspiration pneumonia should be followed by a modified barium swallow in those eating food by mouth (PO), then the diet that is recommended through the completion of a MBSS would be used as a clinical indicator that treatment is timely and justified. If another aspiration pneumonia occurs on the prescribed textured diet, then additional tests should be considered in the pathway, such as evaluation and treatment for GERD. The completion of a diagnostic work up would be a potential clinical indicator, as well as the treatment of GERD. If a proton pump inhibitor is offered, this can be a measurement of treatment. If GERD continues to be symptomatic, a surgical treatment may be indicated, and could be the clinical indicator measured. One of the main tasks of the Medical Director would be to ensure the clinical pathways are understood by the PCPs and followed. Aspects of the clinical pathways should be used as the measurement tool used by QI to determine the adequacy of medical care. When this occurs, the Medical Director could be more confident that health care needs are being met equally across all homes on the campus. The lack of sufficient documentation concerning the efficacy of the psychotropic medication was a significant deficiency in the utilization of these medications at ABSSLC. This subject, as well as potential remedies is discussed in detail with regard to Section J of the SA.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two	At the time of the review, there was no systems approach to health status monitoring. For example, for the areas of dysphagia, GERD, and aspiration, there were no clinical pathways or written guidelines that the Medical Department could use to monitor the	Noncompliance

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	years, a system shall be established and maintained to effectively monitor the health status of individuals.	individuals with these diagnoses to ensure an aggressive diagnostic and therapeutic approach when there were early signs of change in health status. Instead, there was a reaction to a series of severe illness, with continued decline in health status of the individual. As noted elsewhere in this report, it is recommended that a dedicated physical and nutritional management team be organized that would have the responsibility of monitoring the complex problem of dysphagia and aspiration. Without a dedicated team, those with dysphagia are not apt to be followed and monitored and receive early interventions before permanent sequelae develop. The psychiatric status of each individual receiving psychotropic medication was discussed on a monthly basis in the format of the Psychiatric Clinics. These meetings also included a discussion by the Nursing Staff of any medical problems, as well as any apparent side effects of the medications. However, this information was not fully documented in the overall Facility health status assessment process.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	As noted above, the Facility had not developed and implemented clinical indicators or clinical pathways to ensure that medical issues were appropriately identified and interventions implemented to address changing health status. For example, there were many individuals with repeated vomiting, often leading to wheezing and respiratory complications. Part of an adequate clinical pathway, and clinical expectation, would require that at each new acute problem, further review of prior treatment and intervention would be documented. Continuing repeat events indicate that the treatment remains inadequate and additional diagnostic testing or more aggressive treatments need to be implemented. However, at ABSSLC, there were a number of individuals reviewed for which there was no medical intervention to repeated events, such as recurrent vomiting, or recurrent aspiration pneumonia, or there was a medical intervention only after several episodes. Examples are provided below with regard to Section L of the SA. The "clinical indications" that the psychiatrist responded to were primarily represented by the behavioral data presented by the Psychologist in the monthly Psychiatric Clinic. As discussed above, and with regard to Section J, a significant deficiency derived from the observation that the "target behaviors" of the psychotropic medication were also frequently described elsewhere in the record as being present on a learned behavioral basis.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish	According to the Facility's Plan of Improvement, such policies were anticipated to be completed by 6/26/12. This will be further assessed during upcoming visits. For acute care problems, at the time of the review, there were currently no integrated	Noncompliance

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	and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	guidelines to address many of the serious and frequent illnesses at ABSSLC. Recently, the State Office had provided an updated standardized blueprint of health care guidelines for implementation. The Facility will need to review and prioritize them. The clinical pathways needs to be clear as to what test is ordered at what step of the clinical course, with brisk timelines for repeat events. Types of tests ordered, types of treatment offered, and timelines should be clear. Primary care practitioners then should be given the opportunity to provide input, and training should be provided on the final product. Such a process would ensure that expectations are clear and implementation becomes standardized across the campus for that particular health care issue.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. There is need for aggressive diagnosis and treatment when the health status of an individual changes. Critical clinical review of all repeat events, such as pneumonias, aspiration pneumonias, falls with fractures, pica, etc., should lead to further evaluation and treatment, whether medical or surgical, to prevent recurrence.
2. It is recommended that the Medical Director provide clear guidance as to the expected medical work-up and treatment with timelines for many conditions common to the ID/DD population, such as dysphagia, GERD, etc. Clinical pathways should define what is acceptable and timely with regard to examination of the individual, in ordering tests, in providing treatment, the timeliness of further testing, and treatment options when there is another decline or continued signs and symptoms. These clinical pathways or guidelines should be written in such a way as to ensure critical clinical review with action steps at each change in health status or repeat event.
3. As clinical pathways are developed, primary care practitioners should be given the opportunity to provide input, and training should be provided on the final product.
4. Standardization of care through clinical pathways, once implemented, should be measured to ensure that all individuals are treated according to these guidelines, providing confidence to administration that this is occurring.
5. In developing guidance for a number of medical issues, the Medical Director should provide sufficient details within the clinical pathways to allow identification of clinical indicators. Such indicators should be translated into tools by which to measure quality within the Medical Department.
6. Other recommendations regarding the common elements of clinical care are included in other sections of this report.
7. The Facility should continue to develop and implement policies related to the common elements of clinical care.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC All Inclusive Risk Listing, 12/09 through 6/10; o Health Risk Assessment Rating Tools for Individual #340, dated 9/17/09, and 12/16/09; o List of individual that have experienced status epilepticus, since 1/10; o Individuals transferred to a community emergency room for seizures (status epilepticus), since 1/1/10; o List of individuals that have experience GERD, since 1/10; o List of individuals with a diagnosis of GERD; o List of individuals that have sustained a fracture, since 1/10; o Individual with G-tubes/ J-tubes/ tracheostomies, dated 7/13/10; o Individuals with osteoporosis or osteopenia who are at moderate or high risk due to their condition, dated 8/5/10; o Individuals with acute or chronic pain, undated; o Individuals with pica, undated; o ER visits/Infirmary admissions or overnight observations from January through June 2010; o List of individuals with seizure disorder, dated 7/23/10; o List of individuals with intractable seizures, dated 8/4/10; o List of individuals with vagal nerve stimulators (VNS), dated 7/31/10; o List of ER visits for multiple individuals, 1/10 through 6/10; o List of individuals diagnosed with Aspiration Pneumonia/Pneumonia, 1/10 through 6/10; o PSP and PSP Addenda for: Individual #294, dated 9/24/09, and 7/9/10; Individual #511, dated 7/16/09, and 2/17/10; o HST summaries for Individual #294, Individual #511, Individual #377, Individual #100, Individual #317, Individual #431, and Individual #357; and o Health Status Team (HST) summaries from the following homes: 5972, 6330, 6350, 6360, 6390, 6400, 6460, 6480, 6500, 6521, 6690, 6700, 6710, 6720, 6730, and 6740, 3/10 through 7/10 ▪ **Interviews with**: o Dr. Chengson, MD, Medical Director ▪ **Observations of:** o Health Status Team (HST) Meeting, on 8/5/10
	Facility Self-Assessment: In its POI, the Facility identified itself as being in compliance with some individual indicators related to vaccinations and other preventative healthcare procedures. The Monitoring Team considers these to be part of the healthcare requirements found in Section L of the SA. Overall, though, the Facility recognized that it was in the exploratory phase of the risk screening and assessment process, and was not yet in compliance with the requirements in this section of the SA. This is consistent with the Monitoring Team's assessment.

	Summary of Monitor's Assessment: At the time of the review, there were many risk assessment tools being used, but they had not been validated. PSTs were attempting to determine a risk level, but this varied widely across the campus. There was considerable energy and time being spent on risk level assessment, but it was not resulting in accurate assignment of risk levels. In addition, this time expenditure was resulting in teams not planning and implementing plans to reduce risk that had been identified. This appeared to be complicated by the fact the inadequate identification of risk screening tools, and the lack of training provided to team members. Since many of the events that place individuals at heightened risk are medical in nature, it may be best to move the HST process to a core group of nurses, and physicians (with NMT and psychology available for specific cases) to determine the risk level. Such a group would need to meet frequently, on a daily or weekly basis, which could be accomplished at a daily morning meeting as discussed in further detail below with regard to Section L.1 of the SA. This information could then be forwarded to the various PSTs to review, revise, and implement plans as appropriate.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Per report and observation by the Monitoring Team, there were no established, standardized criteria utilized to identify individuals at highest risk. There were multiple lists of individuals identified at high risk by the Health Status Team (HST), Nutritional Management Team (NMT), and other disciplines without the completion of a standardized risk screening assessment and/or benefit of a management system to identify individuals who had complex health, physical and nutritional management needs. The Facility had defined categories of health risk indicators, but there were no established thresholds to trigger further evaluation, including methods and/or intervals of reviews based on degree of identified level of need, and/or occurrence of identified health, physical and nutritional incidents Since the baseline review, ABSSLC had continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As noted from the previous review, this tool was scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. Since the previous review, the Facility had modified this system. Individuals were no longer given an overall score for risk, but were scored for each of the health indicator categories. These indicators were still being discussed at the HST meeting, at which time the physician or practitioner assigned the risk score for each category. Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. Consistent with the findings during the baseline review, the risk tools being used were	Noncompliance

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		not adequate in identifying individuals at risk. Also consistent with the findings during the previous review, the Facility's risk system consisting of the Health Risk Assessment tools, and the HST meetings did not result in the appropriate identification of individuals at clinical risk. However, the Facility continued to use an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. According to the Medical Director, the most valuable information derived from the current risk screening process was to stratify individuals at risk in the home. The team in that home could then provide more oversight, monitor more closely, and hold meetings to discuss updated information, and develop and implement actions to address areas of risk identified for those that were considered at increased risk for a particular concern in the home. The treatment plan could be formulated, and the nurses could also modify the treatment care plan. However, the criteria and tools used to determine risk in the various medical, psychological/psychiatric domains of an individual were too subjective to be reliable indicators of risk. When teams have large and complex caseloads, it is important to prioritize time and resources where it will be most of value. Face validity may be the first step in this process. There were various lists that the Facility had created. These included Infirmary admissions/overnight observations, ER visits and hospitalizations since 1/10, seizure list 7/23/10, intractable seizure list 8/4/10, individuals having experienced status epilepticus since 1/10, individuals transferred to a community ER for seizures (status epilepticus) since 1/1/10, individuals with acute or chronic pain, individuals having a pica diagnosis, individuals with G-tubes, J-tubes, and tracheostomies as of 7/13/10, individuals that have sustained a fracture since 1/10, individuals with a diagnosis of GERD, individuals having experienced GERD since 1/10, and individuals with osteoporosis or osteopenia who were at moderate or high risk due to their condition. Until a validated risk screening process is developed, several of these could be considered excellent resources in determining level of risk. For instance, those that have gone to the ER or have stayed in the Infirmary may be candidates for a higher level of risk. They would need to be screened further, as a single event that is resolved may not require a move to higher-level risk category. But those individuals with repeat admissions for the same reason to the Infirmary, or repeat visits to the ER or admissions to the hospital are likely to be the highest risk individuals. Determining how these lists were created may provide insight to the team as to the next step. For the intractable seizure list, there were 137 individuals in this category, but that included anyone who had a seizure in the last year. Of these, a team could consider	

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		concentrating on those with recent episodes of status epilepticus, or a threshold level of over 10 seizures a month (as an example). It would allow focus on those individuals with the most severe type of seizure or least controlled seizure, which is the goal of risk stratification. In reviewing risk categories, there was confusion within the actual documents. For instance in the Health Risk Assessment Rating Tool for Individual #340, dated 9/17/09, Level 1 was considered low risk, Level 2 was considered medium risk, and Level 3 was considered high risk. However, the Health Risk Assessment Rating Tool for Individual #340, dated 12/10/09, reversed the Level with correlating severity rating. Level 1 was considered high risk, Level 2 was considered medium risk, and Level 3 was considered low risk. To complicate understanding further, the ABSSLC All Inclusive Risk Listing assessed risk as Level 1 = high, Level 2 = medium Level 0 = low. One of the first steps in creating an at-risk list system will be standardizing terminology and procedures, and training staff on the definitions, as well as the procedures for stratifying level of risk. By changing the methodology with some frequency, this had only added confusion to the understanding among PST members. A number of health status team meeting minutes were reviewed. There was a wide variety of reporting formats used in the minutes, which added to the confusion regarding the decision-making process. The team process and forms submitted should be standardized across the campus. Some teams had documented a review of the individual similar to the information one would expect at an annual PST meeting. The cover sheet included all the individuals assigned to that team and presented in capsule form the categories in which individuals were at increased risk. In these instances, there was often far too much information to process at such a team meeting, and the priority issues could easily be lost in the process. At other times, there was not the latest up-to-date information available, which would hamper appropriate decision-making. For example: ▪ In the case of Individual #357, there was no record of her surgery to correct her rectal prolapse that occurred 5/10/10, or of the hospitalization for malignant hyperthermia on 5/19/10. The meeting was held 5/20/10, and although the hospitalization for malignant hyperthermia remained inconclusive at the time of the meeting, the team should have known about the surgery of 5/10/10. Part of the risk stratification process is to determine risk using the most recently available information, and to reconvene rapidly if needed based on new information that would have an impact on risk. Many teams provided coversheets with each individual named and bullets of categories of risk. This was helpful to simplify the information so that team members could then review and process the information. Other team minutes did not have summaries, and listed potential risk factors, but did not list a final risk level, at least from the information submitted. The different team formats and minutes	

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		suggested need for leadership in this area and a standardization of reporting information. Perhaps the most problematic concern for the current risk system was the subjective decision-making for risk categorization. The interpretation of risk seemed to vary from one unit to another. Based on observations of the HST meeting that was conducted on 8/5/2010, the team members spent much of the time struggling with how to rate the individual's risk status, rather than reviewing the care and treatment the individuals were receiving. The lack of criteria for defining the risk categories prevented the system from being accurate and consistent. In addition, from observing the HST's process, events such as injuries, hospitalizations, or other acute episodes were reviewed as isolated incidents. Once the event was resolved, the team seemed to automatically lower the risk level even though the health risk continued to exist. The current system was based on a reactive model in that an individual usually had to experience an acute event in order to have their risk level increased. Once the acute event was resolved, the risk levels were usually lowered, even though the individual continued to have the same health complications that precipitated the acute event. The following examples show that the current system also was unable to meet promptly to address the risks of the individual. When there is a new health concern leading to hospitalization, or an ER visit, risk needs to be reviewed at that time, and urgent attention needs to be paid to the modification and/or implementation of plans. The current system was unable to accommodate the quick reaction time needed to address new and changing risk conditions. For example: ▪ Individual #431 had a number of episodes of vomiting since 3/10, and a diagnosis of pneumonia in 4/10. However, the "ABSSLC All Inclusive Risk Listing" did not mention any risk for GI concerns, which was closely associated with her respiratory issues. The information for the all-inclusive list pre-dated the GI concerns. Additionally, her latest Health Status Team summary of 3/11/10 only mentioned osteoporosis and urinary tract infections as moderate risks, and did not list anything else. When reviewing the Health Status Team recommendations and signature sheet, it listed the diagnosis of osteopenia, not osteoporosis. It was not recorded how the team determined that this should be one of two moderate risk concerns for this individual. The last Health Status Team meeting of 3/11/10 pre-dated much of the recorded vomiting since that time, which was used to develop the all-inclusive summary list. However, the frequency of vomiting as well as the development of pneumonia should have prompted a review of her health status and a review of her risks. However, the system seemed to be too inflexible or unable to meet to review risks, and develop and implement plans based on changes in health status risk. It was to meet in five months for a review, when she would have benefited from a meeting	

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		following her pneumonia in 4/10. One of the criteria of a working and successful health risk assessment system is the ability to meet quickly to meet the needs of the individual. ▪ Individual #317 was diagnosed with bilateral pneumonia on 3/26/10, but the respiratory risk rating until then was considered low. The team was not to meet again until 8/19/10, but given her health status change with a diagnosis of pneumonia in 3/10, there should have been a mechanism to review her risk level prior to the next scheduled health status team meeting. ▪ Individual #377 continued to have status epilepticus, yet was categorized low risk for seizures by the team, according to the "All Inclusive Risk Listing," however, the team met on 3/11/10 and determined her to be at medium risk. There appeared to be a discrepancy in the "All Inclusive Risk Listing" with the team minutes. With her more recent status epilepticus, the team should have met to reconsider the risk level. Those with status epilepticus are often elevated to high risk until seizure control improves. ▪ Individual #511was listed medium risk for aspiration, and as low risk on 3/18/10 in the categories of weight and respiratory, but was currently clinically challenging in both these areas. His recent pneumonia suggested the need to revisit his risk status, and implement additional plans until his pneumonias did not recur. Also, he had considerable problems with anorexia and poor intake by mouth, but as most of this occurred after the last HST meeting, a critical area of health for which he has been at risk for several months was not reflected in an updated risk assessment nor risk plan. ▪ Individual #100 had been hospitalized for repeated pneumonias, yet was determined to be at low risk for respiratory problems at a team meeting on 3/9/10, but a medium risk for aspiration. Care plans were implemented for the aspiration. He since developed another severe pneumonia in 7/10, and the team should have met to review his risk category and implement steps to reduce his risk. The next meeting of the HST was to be 8/12/10. It was noted that the PST met every 60 days on this individual. However, the severity of his pneumonia indicated that his care plans for his aspiration needed to be reviewed, as well as consideration of a risk status for respiratory issues. ▪ Individual #294 had repeated vomiting, with diagnoses of pneumonia on 5/4/10 and 6/23/10. However, the risk listing indicated low risk for respiratory conditions, because they had not met on him since 3/9/10. Upon review of many of the risks per individual, it was observed that there was little difference made between a problem that was life-threatening and one that was not life-threatening. For those with multiple high-risk areas, the teams needed to prioritize those with the most urgent diagnosis or diagnoses that needed resolution. At the time of the review, the teams were generating considerable energy in determining level of risk,	

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		but it did not seem to produce the intended effect of determining the most critical areas needing urgent attention, from all the areas of each individual's health needs. Unfortunately, it may have led to some distraction away from these most urgent concerns, with focus on developing risk lists, rather than implementing plans to reduce priority risks. Based on the review of these individual's risk stratification and the timing of the meetings, it was clear there was a critical gap between health events and team meetings. In reviewing individuals' risk categories, the teams appeared to have taken every major diagnosis and made it an elevated risk, regardless of the stability of that condition. This will only add burden to the system in attempting to prioritize problems. It should be the urgent concerns with potential for health status decline in the near future that represent one criterion to be used. If the individual has demonstrated repeat complications from a chronic illness (such as multiple fractures from osteoporosis), that would also be a high-risk criterion. Such criteria need to be developed to guide the teams in determining what is truly high risk, not simply identifying their diagnoses and considering them all moderate to high risk, when many of them have been stable. This being said, there may be some diagnoses that require constant vigilance, and, for example, would require ongoing oversight and monitoring by the PST and/or PNMT. For example, some individuals with severe dysphagia might need to remain at a high-risk level due to the need for constant monitoring and review by the team to ensure their supports meet their needs. Since many of the events that place individuals at heightened risk are medical in nature, it may be best to move the HST process to a core group of nurses, and physicians (with NMT and psychology available for specific cases) to determine the risk level. Such a group would need to meet frequently, on a daily or weekly basis, which could be accomplished at a daily morning meeting as discussed in further detail below with regard to Section L.1 of the SA. This information could then be forwarded to the various PSTs to review, revise, and implement plans as appropriate. Individual teams do not necessarily have the health care background to determine which individuals are at highest risk. A core team would standardize the approach across the campus and could respond readily to an individual's needs, as they would know who has been hospitalized, sent to the ER, etc., and who was in need of urgent risk review. For timeliness, it is recommended that this be a daily "morning report" meeting, with all PCPs and supervising nurses who can together review the prior 24 hour reports from the homes. This may require standardization of reporting from each home with completion of documentation for review by the time of this meeting. At this meeting, the decision for risk categories would be included as part of the daily review of ongoing health problems. With the Medical Director caseload decreasing, this would be an opportunity for providing leadership with regard to the risk identification process, and an appropriate	

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		role as chair of the daily meeting. The Risk System should be the essential foundation that identifies those individuals who warrant the most clinical intensity, and is the alarm for other systems to be called into action. There should be criteria for the risk categories to ensure consistency, and so that the process is less subjective. The Facility and the State Office recognized that they were not in compliance with this requirement of the SA, which is consistent with the Monitoring Team's findings. Once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The following provide some examples of individuals at risk for whom adequate assessment and planning was not completed. ▪ A PSP was reviewed for Individual #294, including several addendums. The latest submitted was dated 7/9/10. Aspiration continued to be medium risk, but there was mention of vomiting with aspiration and a diagnosis of pneumonia. However, respiratory status was considered stable, with episodes of vomiting resolved three months ago, and overall status unchanged. Yet on 6/15/10 and 6/19/10, he had significant vomiting leading to pneumonia. This was not captured in the information concerning aspiration. It was discussed under the topic of gastrointestinal (GI) concerns, but he was considered stable and no further testing or assessment or referral to a consultant was considered. The PSP addendum did not consider his risk for further pneumonias and vomiting and implement either a diagnostic work-up plan or treatment plan. The purpose of the risk stratification system did not seem to impact the decision-making process of the team. ▪ Individual #511 had a PSP addendum dated 2/17/10 in which his weight loss was considered a medium health risk. He had been discharged from the NMT according to his prior 7/16/09 PSP. The updated risk category for weight categorized him as low risk for weight problems as of 3/18/10. At the time of the PSP addendum of 2/17/10, the response from the team was for the RN to write acute care plans for weight loss. There was no further PSP addendum that addressed this issue or other team member involvement. That he had pneumonias in 12/09, 5/10 and 7/10 did not seem to be reflected in the PSP process to reconsider risk (he was considered low risk for respiratory problems from the "All Inclusive Risk Listing"), and it would have been a critical time after each hospitalization or prolonged Infirmary admission for the PST to convene and discuss how to lower his risk for future infections. No information was recorded as to the next step in assessing the cause and resolving the problem. The Physical and Nutritional Management Team (identified as the Nutritional	Noncompliance

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		Management Team by ABSSLC) met on a frequent basis, but did not complete comprehensive assessments, develop and implement intervention plans, train staff, and/or review and monitor the efficacy of these interventions for those individuals with complex physical and nutritional management needs as documented in detail below with regard to Section O of the SA.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	There had been considerable time and effort spent attempting to understand risk levels and create a risk system that was practical and effective. The Facility was still struggling with this concept. However, it has not been able to implement effectively risk reduction plans. The two PSP addendums of Individual #294 and Individual #511 as discussed above with regard to Section I.2 of the SA were evidence of this. The risk screening, assessment and planning system was at the initial exploratory phase of development and will need much additional guidance and energy to be used as an effective and efficient tool in reducing morbidity and mortality in the individuals that reside at ABSSLC. As mentioned above, an alternative daily morning report meeting with physicians and nurses may be more efficient and effective in creating and implementing a valid risk assessment program.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. At-risk criteria need to be developed that:
    a. Are easy to interpret by a wide audience of participants;
    b. Represent true and valid risks of the individual at that time;
    c. Have a concrete and measurable component that guides teams as they determine when someone is placed on or taken off an at risk list
    d. Have sufficient specificity to detect the highest risk individual without creating so many false negatives that those deserving urgent attention are missed;
    e. Have sufficient sensitivity to detect the highest risk individual without creating so many false positives that it dilutes efforts away from those who need it; and
    f. Provide precise criteria so each unit across the Facility is using the same measurement system.
2. As appropriate, the State should consider identifying and implementing standardized tools to be used by all the Facilities in assessing and documenting clinical indicators of risk. These standardized tools should be selected based on their reliability and validity, as well as their ability to provide a weighted score, and meaningful clinical information to allow teams to identify objectively individuals' level of risk in the appropriate clinical areas.
3. In addition, there is a variety of information available from which to identify individuals who are potentially at risk, such as incident

management data. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.

4. The Health Status Team meeting format should be redesigned to ensure that appropriate criteria and structure are in place to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in the teams identifying an associated level of intensity of clinical supports to address the risks, as well as proactive measures aimed at preventing risks.
5. An option that should be considered to strengthen the HST meetings is a daily morning meeting of health professionals, chaired by the Medical Director, to learn of all the urgent health care concerns on campus over the prior 24 hours, but also to assess a level of risk and forward that information to the HST and PST for planning and development. The HST, in conjunction with the PST, should then develop plans to address the risk, and monitor the implementation of the plans.
6. If the HST process is going to continue to be used, it needs to be revised to:
    a. Allow for more rapid response to a change in health status to address a new risk issues immediately as the individual requires;
    b. Have access to updated information in order to make a determination of risk and in order to monitor the risk;
    c. Be standardized across the campus;
    d. Focus on priority health needs that could potentially have severe consequences if not attended to urgently; and
    e. Have standardized formats for minutes.
7. The Facility should develop and implement interdisciplinary assessments of services and supports for the individuals identified as at risk, and in response to changes as measured by established at-risk criteria, according to the required timeframes set forth in the Settlement Agreement.
8. As required by the SA, for each individual assessed, the Facility should establish and implement a plan within fourteen days of the plan's finalization, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk. More immediate action should be taken when the risk to the individual warrants. Such plans should be integrated into the PSP, and should include the clinical indicators to be monitored and the frequency of monitoring.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individuals Prescribed Intra-Class Polypharmacy for June, 2010; o Example of (blank) Sedation Log Sheet; o The Polypharmacy sections from the most recent Health Risk Assessment Tool for all individuals whose psychotropic medication regimens met the definition of polypharmacy; o Schedule and dates of all Psychiatric Treatment Reviews for the last year; o List of all Meetings and Rounds that are typically attended by the Psychiatrist, including other professional disciplines that usually attend those meetings; o Board Certified documentation status for John Crowley, MD and Patricia Lowrimore, MD.; o Example of (blank) Contract for Psychiatric Services; o List of all Psychiatry Clinics for July, 2010; o Curriculum Vitae of Patricia Lowrimore, M.D.; o State Job Description for Psychiatrists; o List and (blank) examples of all forms used by the Psychiatrists at the ABSSLC; o Minutes of Polypharmacy Review Committee Meetings for 5/3/10, 6/15/10, and 7/5/10; o Response to requests for documentation pertaining to complaints about the psychiatric and medical care given at the ABSSLC, since 1/1/10 (Response: No complaints); o List of most recent (6/23/10 through 7/7/10) ten individuals prescribed psychotropic medication and related documents; o Current list of families/guardians that refused to authorize psychiatric treatments and/or medication recommendation; o List of all individuals admitted since 1/1/10 receiving psychotropic medications; o List of all psychiatric treatment reviews for the last calendar year; o The psychotropic medication spreadsheet for Guardian Consent for Psychotropic Medication for the time period of 1/1/10 through 7/31/10; o Emergency Medication and Administration Protocol and examples of completed forms; o The medical records of the following individuals: Individual #2, Individual #331, Individual #149, Individual #268, Individual #11, Individual #310, Individual #293, Individual #23, Individual #300, Individual #398, Individual #388, Individual #518, Individual #327, Individual #63, Individual #365, Individual #532, Individual #79, Individual #252, Individual #8, Individual #160, Individual #61, Individual #387, Individual #115, Individual #13, Individual #163, Individual #48, Individual #127, Individual #490, Individual #455, Individual #103, Individual #216, Individual #260, Individual #81, Individual #537, Individual #32, Individual #151, Individual #438, Individual #136, Individual #154, Individual #464, and Individual #120; o The most recent Psychiatric Problem List for all individuals who have a psychiatric diagnosis; o List of all individuals receiving anticonvulsant medication;

	○ The Reiss Screen and the Psychiatric Consultation that was performed due to the elevated score for the following individuals: Individual #502, Individual #467, Individual #170, and Individual #527; ○ The Reiss Screen for the following individuals: Individual #543, Individual #427, Individual #271, Individual #314, Individual #183, Individual #224, Individual #458, Individual #97, Individual #492, Individual #270, Individual #422, Individual #110, Individual #349, Individual #141, Individual #148, Individual #520, Individual #264, and Individual #152; ○ The documentation from the 8/2/10 Psychiatry Clinics on Homes 6500 and 5972, and the 8/3/10 Psychiatry Clinic on Home 6760 for the following individuals that were reviewed on those days: Individual #109, Individual #5, Individual #49, Individual #8, Individual #518, Individual #439, Individual #216, Individual #23, Individual #454, Individual #201, Individual #300, Individual #149, Individual #79, Individual #115, Individual #2, Individual #523, Individual #301, Individual #130, Individual #325, and Individual #396; ○ The Sedation Log Instruction Sheet, dated January 2010; ○ Spreadsheet of Psychiatric Reiss Examinations Report for all individuals at the ABSSLC who had been administered the Reiss Examination in 2009 and 2010; ○ Listing of all individuals receiving psychotropic medication with notation of Attending Psychiatrist, dated 7/9/10; ○ The template for the Psychological Plan to desensitize individuals for medical and dental appointments from 6/1/10 through 6/30/10, and the actual Program Plan for Individuals Individual #242, Individual #491, and Individual #252; ○ List of individuals receiving anticholinergic medication; ○ List of all individuals currently prescribed Metoclopramine (Reglan); ○ The documentation related to Dr. Lowrimore's Psychiatric Consultations on Individuals Individual #245, dated 5/17/10; Individual #293, dated 6/29/10; and Individual #268, dated 5/10/10; ○ Spreadsheet documenting all chemical restraint use behaviors for FY10; ○ Documentation of initial and annual Competency Evaluations of nurses to administer the Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS); ○ Example of monitoring tools for: psychotropic medication, two tools for section J, dated 8/5/10; ○ Quality Enhancement Services (QES) Nurse quarterly report for FY10 quarters 1, 2, and 3 for psychiatry in color, dated 8/5/10; ○ QES data related to the existence of behavior support plans for individuals receiving psychotropic medication, dated 8/5/10; ○ QES data related to the use of pre-treatment sedation medication, dated 8/5/10; ○ QES data related to the use of emergency use of psychiatric medication, dated 8/5/10; ○ QES data related to the documentation of consents for the use of psychotropic medication, including sample sizes, all of the above for FY10, quarters 1 ,2, and 3, dated 8/5/10; ○ Minutes of the two (most recent) Pharmacy Therapeutics Committee Meetings, dated 4/30/10 and 7/28/10;

	○ Antiepileptic and Psychotropic Surveillance Studies and Drug Level Monitoring, dated 5/28/09 ○ New State Approved Psychiatric Services Policy, dated 7/28/10; ○ The Human Rights Committee Report Spreadsheet – Psychology; and ○ The behavior support plan tracking sheet and related documents for the 8/4/10 Behavior Support Committee Meeting and Attendance Sheets for the following individuals that were reviewed on that day: Individual #4, Individual #123, and Individual #439 ▪ **Interviews with**: ○ Toni Wilson, Psychiatric RN; and Marcos Perez, Psychiatric Assistant, on 8/2/10 and 8/5/10; ○ Dr. Patricia Lowrimore, Consulting Psychiatrist, on 8/3/10; ○ Ms. Kalana Allen, Records Coordinator, on 8/3/10 and 8/5/10; ○ Ms. Jill Antilley, Assistant Independent Ombudsman, on 8/3/10; ○ Cathy Hennington, Director of Behavioral Services; and Ron Manns, Board Certified Behavioral Analyst, on 8/4/10; ○ Shea Butts, Human Rights Officer, on 8/4/10; ○ Jim Kluza, RN, Chief Nursing Executive (CNE), on 8/4/10; ○ Richard Chengson, MD, Medical Director, on 8/4/10; ○ Marla Knight, Pharm.D., on 8/4/10; and ○ Patricia Smith, Admissions and Placement Coordinator (APC), on 8/5/10 ▪ **Observations of**: ○ Individual #109, Individual #5, Individual #216, Individual #439, Individual #345, Individual #40, Individual #21, Individual #311, Individual #265, Individual #145, Individual #204, Individual #183, Individual #8, Individual #49, Individual #403, Individual #303, Individual #23, Individual #245, Individual #151, Individual #25, Individual #180, Individual #229, Individual #169, Individual #293, Individual #313, Individual #115, Individual #224, Individual #2, Individual #149, Individual #396, Individual #357, Individual #300, Individual #43, Individual #231, Individual #417, Individual #463, Individual #19, Individual #110, Individual #268, Individual #510, Individual #167, Individual #383, Individual #447, Individual #504, Individual #267, Individual #503, Individual #467, Individual #132, Individual #163, Individual #455, Individual #274, Individual #286, Individual #272, Individual #440, Individual #50, Individual #303, Individual #469, Individual #106, Individual #165, Individual #321, Individual #375, Individual #387, Individual #491, and Individual #199; ○ The Psychiatry Clinics of Dr. Patricia Lowrimore at Homes 6500 and 5972 on 8/2/10; and at Home 6766 on 8/3/10; ○ The Behavioral Support Plan Committee Meeting on 8/4/10; and ○ The Health Status Team Meeting at Home 6370 on 8/5/10
	Facility Self-Assessment: The primary empirical efforts related to the ABSSLC's Self-Assessment of the Psychiatric Services were the internal studies that had been carried out by the Quality Enhancement Services (QES). The review templates that had been developed closely follow the stipulations set forth in

	the Psychiatry section of the Settlement Agreement. The Nursing QES Quarterly Report for the second quarter of Fiscal Year 2010 (FY10) concluded that: "Psychiatric Services has suffered a significant decrease in compliance over the last three quarters. The loss of a full-time Psychiatrist has had a significant effect on the data regarding annual comprehensive assessments. However, in-servicing of the contract psychiatrist was completed and a new system of assessments and dictation was implemented this quarter. Due to the manner in which the random sample is drawn for this monitoring, any improvements in the data may not be seen for a while." The Facility's self-assessment completion/compliance rates for the various subsections of the requirements related to Psychiatry Services documentation were higher than those found in the following sections of this report. That discrepancy derives from the observation that the QES Reviews were utilizing a dichotomous yes/no process to determine if the documentation described in the Settlement Agreement was present or absent. The analyses described below also assessed this documentation for the quality and "clinical justification" terms of the Settlement Agreement. The QES Review also should incorporate these factors into their future reviews.
	Summary of Monitor's Assessment: The ABSSLC employed two part-time psychiatrists to provide psychiatric services to the 225 individuals who are prescribed psychotropic medications. Dr. Patricia Lowrimore provided on-site psychiatric services at the ABSSLC approximately 11½ hours per week, distributed over two days. She usually arrived at 12 noon on Monday and finished by 5:00 p.m. that day. She then returned at 8:00 a.m. on Tuesday and ended the day at 3:00 p.m. This time was allocated to the monthly Psychiatric Clinics, which included quarterly observation of the individuals. Time was also allocated to urgent psychiatric consultations, which took place on the living units. Dr. John Crowley provided psychiatric services in a similar format: He was on-site from 1:00 p.m. to 5:00 p.m. both Monday and Tuesday of each week. The Psychiatry Department had one full-time Psychiatry Nurse, as well as two full-time Psychiatry Assistants. The support provided by these professionals had provided the structure required to ensure that the Psychiatric Clinics took place on a monthly basis, and that the Psychiatrist saw each individual on a quarterly basis. The Facility had made considerable progress toward meeting the provisions of the Settlement Agreement related to the MOSES/DISCUS side effect monitoring, as well as the administration of the Reiss screening instrument. The analysis of the medical records of individuals served by ABSSLC described in detail below identified three fundamental problems, including: 1. The identification of the specific symptoms that support the psychiatric diagnosis was inconsistent. 2. In several records, the behaviors that were described as "targets" of the psychotropic medication also were referred to in the Behavior Plan and Functional Analysis as being present on a learned-operant basis and/or a response to environmental factors.

	3. There was a lack of documentation that would confirm that the psychotropic medication had been useful in reducing the frequency and severity of the behaviors they were prescribed to address. These topics are discussed in more detail in the report that follows, as well as in the Recommendations section. Review of the documentation in the records indicated that consent for psychotropic medications was being obtained routinely. Either a guardian or the Facility Director had signed these forms. However, the Risk-Benefit Analyses upon which the consents were based did not provide sufficient information upon which to make a truly informed decision. ABSSLC had implemented a monthly meeting to address polypharmacy with psychotropic medication. Drug regimen reviews performed by the Pharm. D. provided valuable feedback to both the Primary Care Physician and the Attending Psychiatrists. Systems should be implemented to ensure that these documents are reviewed by the appropriate physician and responded to in a timely manner. QES had performed useful analyses of the provision of psychiatric services as related to the provisions of the Settlement Agreement. The process of meeting these provisions of the Settlement Agreement could be facilitated through an expansion of the Department's resources to enable larger sample sizes for their QE record reviews, and as mentioned above with regard to the Facility's self-assessment, a more qualitative analysis.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Patricia Lowrimore was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. During the interview, which took place on Tuesday, 8/3/10 in the Psychiatry Services office, she indicated that in addition to her consultation at ABSSLC that she also provided psychiatric services to individuals with intellectual/developmental disabilities (ID/DD) and brain injury through her private practice in Dallas. The Facility also contracted with Dr. John Crowley, who is Board Certified in both Adult and Child Psychiatry by the American Board of Psychiatry and Neurology. Thus, his caseload included the children and adolescents who resided at the ABSSLC. Dr. Crowley was on vacation at the time of the tour and could not be directly interviewed. The Psychiatry Assistants were able to provide an overview of Dr. Crowley's role in the provision of psychiatric services at the ABSSLC. As is discussed in further detail below with regard to Section J.5 of the SA, although both consulting psychiatrists were qualified to provide services to individuals with co-existing	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		mental health concerns and ID/DD, the limited number of hours they were available to the Facility significantly impacted the quality of services provided. The Facility was making efforts to identify additional psychiatric coverage. As additional psychiatrists are engaged by the Facility, the Monitoring Team will review and evaluate their credentials.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Dr. Lowrimore's time commitment to the ABSSLC consisted of approximately 11½ hours per week. Her usual schedule was to arrive on Monday at 12 noon and finish at 5:00 p.m. However, during the observation of the Psychiatry Clinics on 8/2/10, it was noted that she stayed until at 6:00 p.m. to perform an emergency Psychiatric Consultation. She then would typically return the following day at 8:00 a.m., and usually finished by 3:00 p.m. Dr. Lowrimore devoted this time to the monthly Psychiatry Clinics, routine Psychiatric Consultations, and Urgent Consultations. These meetings all took place on the living units. The individuals were directly observed on a quarterly basis. One Psychiatric Nurse, as well as two Psychiatric Assistants supported the Psychiatrists. The Clinical Nurses and Psychologists on the residential units also worked with the staff of the Psychiatry Department to schedule the Psychiatry Clinics and the direct observations of individuals by Drs. Lowrimore and Crowley. The goal of the Psychiatry Department at ABSSLC was to have every individual reviewed on a monthly basis, and directly observed by the Attending Psychiatrists on a quarterly basis. The administrative support described above enabled the two Psychiatrists to achieve this goal. The review of the individual records of the individuals who were receiving psychotropic medication (methodology is described with regard to Section J.13 below) indicated that the goal of a monthly review in the Psychiatry Clinic was documented for all of the individual records reviewed. The corresponding goal to observe every individual at least quarterly also was attained for all of the individual records reviewed, or an explanation was provided as to why the interview could not occur on that day. The review of this sample also indicated that there was a full Psychiatric Evaluation (within the last two years) for all but the following Individuals: Individual #13, Individual #61, Individual #438, Individual #455, Individual #81, Individual #127, Individual #32, Individual #103, and Individual #136. Thus, a current Psychiatric Evaluation was located for 33 of the 41 records reviewed (80%). This provision of the Settlement Agreement includes the qualification that the evaluation and diagnostic process will be conducted "in a clinically justifiable manner." Systematic deficiencies in all of the initial assessments in this sample included: 1. A lack of the identification of the specific symptoms that support the *DSM-IV-TR* Axis I and Axis II diagnoses. 2. There was no, or very little documentation in the assessments as to how the identified target behavior (usually aggression and/or agitation) was	Noncompliance

#	Provision	Assessment of Status	Compliance
		derived from and related to the identified psychiatric diagnosis for which the medication was prescribed. These factors relate to the requirement that the psychiatric diagnosis should be clinically justifiable. 3. A related issue was that these deficiencies were also found in the Monthly and Quarterly Reviews. The behaviors that were identified as "targets" of the psychotropic medication often also were described in the Functional Analysis and Behavior Support Plan as being present on a learned or operant basis. (Additional detail concerning this is described below with regard to Section J.13). Those initial assessments that were found to otherwise meet the requirements for a thorough assessment were for the following individuals: Individual #268, Individual #115, Individual #274, Individual #160, Individual #163, Individual #216, Individual #23, Individual #518, Individual #63, Individual #79, Individual #8, and Individual #154. It is noteworthy that the Psychiatry support staff, working in conjunction with the Consulting Psychiatrists, had been able to develop the infrastructure that enabled them to complete the periodic ongoing reviews that were compatible with the timelines identified in the Settlement Agreement, and Health Care Guidelines. Implementation of changes to the psychiatric assessment format that address the deficiencies identified above should make it possible to move the process closer to compliance with the specific terms of the Settlement Agreement related to the quality of the evaluations and assessments.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	There was no indication that psychotropic medication was utilized at ABSSLC as a punishment, or for the convenience of the staff. All of the individuals who received psychotropic medication had a treatment program and one or more psychiatric diagnoses. However, as will be discussed in more detail with regard to Section J.13, psychotropic medication was utilized for individuals whose behavioral programs were not adequate, and in many cases, the psychiatric diagnosis on record was not supported by adequate documentation in the clinical record with regard to the symptoms that support the diagnosis. In addition, the behaviors that were monitored to assess the efficacy of the psychotropic medications were also frequently referred to in the Functional Assessment and Behavior Support Plans as being present on a learned basis, as a reaction to demand situations, and/or are related to environmental factors.	Noncompliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is	During the 8/4/10 interview with the Director of Behavioral Services and the Board Certified Behavior Analyst, they indicated that the Psychology Department was in the initial phases of implementing desensitization plans to decrease the reliance on the use of pre-treatment sedation medications prior to medical and dental appointments. The	Noncompliance

#	Provision	Assessment of Status	Compliance
	to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	Behavior Analyst had a Masters Degree in Psychology and was also Board Certified in Behavioral Analysis. He had been actively involved in the process of developing the desensitization plans. The ABSSLC had enlisted the services of outside consultants to develop an overall strategy to implement these procedures, as well to develop a template to use in developing individual behavioral desensitization plans, or other strategies to minimize or eliminate the need for pre-treatment sedation. The initial group of individuals that was selected for a Pilot Project related to these procedures was comprised of five individuals who were chosen for the degree of complexity they presented. Two of these individuals did not become engaged in the process. The remaining three were Individual #242, Individual #491, and Individual #252. The review of those Behavioral Desensitization Treatment Plans indicated that they were individualized and thorough. Overall, the program description was found to be detailed and contained a schematic flow sheet to guide the process. This program was too new to evaluate its efficacy at this time. Review of the sample of individuals described with regard to Section J.13 of the SA indicated that pre-treatment sedation for medical appointments and dental procedures had been utilized for a total for 14 individuals in this sample of 41 individuals, including: Individual #331 (Ativan and Chloral Hydrate – dose not specified); Individual #115 [Ativan 3 milligrams (mg)]; Individual #274 (Ativan 1 mg or Chloral Hydrate 1,000 mg); Individual #387 (Ativan 1 mg or Chloral Hydrate); Individual #61 [Phenergan 25 mg PO (by mouth), plus Toradol 60 mg intramuscular (IM), not effective, but subsequent use of Ativan 2mg IM was somewhat effective]; Individual #160 (Thorazine 150 mg or Chloral Hydrate 1,500 mg); Individual #438 (Ativan 2.5 mg); Individual #455 (Valium 20 mg plus Halcion 0.5 mg); Individual #260 (Geodon 20 mg followed by 60 mg an hour later, plus Ativan 1 mg); Individual #81 (Chloral Hydrate 1,000 mg); Individual #127 (Ativan 2 mg); Individual #537 (Haldol 5 mg IM, Ativan 4 mg PO, and Chloral Hydrate 1,000 mg); Individual #310 (Ativan 3 mg); and, Individual #150 (Ativan 2 mg or Chloral Hydrate 1,000 mg). It should be noted that this information was derived from the Pre-treatment sedation Medication Logs, and the specific Doctor's Orders related to the administration of these medications were not in the materials requested. There was no documentation in the Log of the post-administration monitoring of the individual in this section of the record, although it may well exist in other sections of the record, such as the Observational Notes and/or the Nursing Notes. It would be useful to include in this section of the record information regarding the post-administration physiological monitoring of the individuals, in addition to the brief reference to the subjective impression of how effective it was from a behavioral standpoint. The Pre-treatment sedation Protocols that exceeded those that would typically be used included Individuals	

#	Provision	Assessment of Status	Compliance
		#260 and Individual #455. The purpose of the pre-treatment sedation medication for Individual #455 was to facilitate transfer to a psychiatric hospital. Individual #260 is 12 years old, and the justification was not clear in this section of the record for the use of the unusually high dose, although there was no indication in the Psychiatry Clinic Notes or elsewhere in the record that there was an adverse reaction to this. During the 8/3/10 interview with Dr. Lowrimore, she indicated that Psychiatry would not be consulted by Medicine for input on pre-treatment sedation orders unless the routine protocols were not effective and there was a need to consider more aggressive strategies.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	There were 225 individuals who were prescribed psychotropic medications at ABSSLC. Three full-time Psychiatrists (or the equivalent amount of Consulting Psychiatrists) would be required to adequately evaluate and provide psychiatric services to the individuals who reside there. This would equate to a caseload of approximately 75 individuals for each Psychiatrist. Many of the individuals who reside at ABSSLC present with complex psychiatric disorders, and the current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this is a reasonable estimate. The Facility had relied on the part-time commitment of Drs. Patricia Lowrimore and John Crowley to provide the day-to-day psychiatric care to all of the 225 individuals who were receiving psychotropic medication. The combined time commitment of Drs. Lowrimore and Crowley totaled approximately 20 hours per week, which was approximately one-half of a full-time equivalent psychiatrist. During the interview with the Facility's Medical Director, on 8/4/10, he described the efforts that ABSSLC had undertaken to recruit additional psychiatrists, which had included an increase in salary, networking with local physicians, and advertising in national publications. Thus, the Facility administration was making an active, sustained effort to address this deficiency.	Noncompliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as	As noted above, two psychiatrists who worked on a contractual basis provided the psychiatry services at ABSSLC. The primary contact that the psychiatrist has with the individuals and their teams took place in the context of the monthly Psychiatric Clinics. Each individual was reviewed monthly and directly observed by the psychiatrist every three months. The monthly meetings, including the quarterly observations, occurred as scheduled. This was evident in each of the records reviewed in both the random and non-random sample. The Psychiatry Nurses, Psychiatry Assistants, and the living unit Nursing Staff, working in conjunction with the members of the Psychology Staff, contributed to the successful execution of this schedule of Psychiatric Clinic reviews.	Noncompliance

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	described in Appendix B.	Current Psychiatric Assessments were identified in 80% of the records reviewed. Deficiencies related to both the documentation of the Psychiatry Clinics and the Psychiatric Assessments are described in more detail with regard to Sections J.2 and J.13 of the SA. The missing documentation related to the identification of the symptoms that support the psychiatric diagnosis; the information that would link the monitored behavior, such as aggression, agitation, and/or self-injurious behavior, to the psychiatric diagnosis of record; and empirical data that would substantiate that the psychotropic medication had been effective. The latter point is important, in that this information is necessary in documenting that the benefits of the medication(s) outweigh the risk that they present, based on their side effect profile(s).	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	At the time of the review, the total population of the ABSSLC was 452. Two hundred and twenty-five individuals were receiving psychotropic medication. The Reiss Screen was specifically used to identify individuals who were not receiving psychotropic medication who could benefit from a Psychiatry Consultation. The spreadsheet of individuals who had been administered the Reiss Screen in 2009 and 2010 indicated that during this timeframe this screening instrument had been administered to 186 individuals. The data reviewed above would indicate that the Reiss Screen has been administered to 186 out of 227 (82%) of the individuals that were eligible for this screening procedure. In order to assess the validity of the spreadsheet, a random sample of 10% (every tenth individual) was requested of the individuals who were identified in the spreadsheet as having been administered the Reiss Screen. **RANDOM SAMPLE** <u>Individual</u> <u>Date</u> Individual #543 8/13/09 Individual #427 1/21/10 Individual #271 12/18/09 Individual #422 8/18/09 Individual #110 12/15/09 Individual #314 8/14/09 Individual #183 12/21/10 Individual #224 3/31/10 Individual #97 4/15/10 Individual #492 9/30/09 Individual #270 3/12/10 Individual #458 12/29/09 Individual #349 4/19/10 Individual #141 3/31/10	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #148 1/19/10 Individual #520 7/30/09 Individual #264 1/5/10 Individual #152 11/12/09 The spreadsheet also indicated that the scores for maladaptive behaviors on four of the protocols were above the threshold that would prompt a Psychiatry referral. The documentation for these individuals was requested and indicated that: Individual — Date of Reiss Screen — Date of Psychiatry Consultation Individual #502 7/28/09 10/21/09 Individual #467 12/15/09 3/15/10 Individual #170 9/15/09 3/15/10 Individual #527 1/28/10 7/26/10 In summary, the census of ABSSLC is 452. Psychotropic medication was administered to 225 of these individuals, and, as part of the process, each one had had a Psychiatric Evaluation. Thus, the spreadsheet data provided would suggest that the Facility had met this requirement for 82% of the population that was eligible for screening with the Reiss instrument. The analysis of the random sample indicated that the data contained in the spreadsheet was reliable. Reiss Screens need to be completed for the remaining 18 percent of the individuals who need them. In addition to need for additional screening to be completed, concerns were noted with regard to the lapse of time between screenings indicating a need for further evaluation, and the more in-depth assessments being completed. For the sample reviewed, it took between three and six months for the psychiatric assessments to be completed. In addition, as noted above with regard to Section J.6 of the SA, the psychiatric assessments that were completed did not meet the requirements of the SA.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	During the course of the on-site review on Monday (8/2/10) and Tuesday (8/3/10), it was possible to directly observe 6½ hours of one of the Consulting Psychiatrist's interactions with the clinical teams. These observations provided ample evidence that the Consulting Psychiatrist worked closely with the members of the Psychology Department. This was evident at both the Monthly Psychiatric Clinics and the Urgent Psychiatric Consultations. The Psychologist who was responsible for the individual being reviewed discussed the behavioral data for the month. It was obvious that the Consulting Psychiatrist relied upon this information when making decisions regarding the use of psychotropic medication, and when implementing changes to an individual's pharmacological regimen.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Within the sample of individual records reviewed, it was evident that each individual who was prescribed psychotropic medication had an active, Positive Behavioral Support Plan. The areas in which there were deficiencies in the integration of psychiatric services and psychological services were as follows: ▪ In several of the records reviewed, the symptoms that were described as being "targets" of psychotropic medication also were described in the functional analysis as being present on an operant basis, or a response to a demand situation, representing an escape behavior, or being related to environmental, stressful events. (This is discussed in additional detail with regard to Section J.13 of the SA.) It is conceivable that the symptoms of a psychiatric disorder could be affected by these factors, but the documentation necessary to support such a connection was often not present. This suggested that the psychotropic assessment process and the psychological assessment process were operating in a parallel manner and were not integrated. This dual documentation also gave the impression that the psychotropic medication was being prescribed to suppress "target behaviors" such as "Aggression," "Agitation," and "Self-Injurious Behavior (SIB)," rather than the symptoms of an identified psychiatric disorder. Based on the available documentation, an external reviewer could not substantiate that the medications were being prescribed for the symptoms of an identified psychiatric disorder. ▪ The integration of psychiatric services with psychological services at ABSSLC could be improved through the integration of the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so that it is clear in both which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies. These plans should be integrated with one another through the PSP process/document. In those cases where the identified behavior was thought to be determined by both biological and psychological processes, this should be clarified.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the	This provision describes a collaborative process through which "the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition." There was insufficient documentation in the records reviewed that this collaborative process was occurring at ABSSLC. Although there were forums at which discussion could have occurred to ensure that the least intrusive, most positive approaches were being used, such as the Psychiatry Clinics and PSP meetings, these forums were not being used for these purposes. More specifically, the Psychiatry Clinics were attended by multiple disciplines, including nursing staff, direct support professionals, psychology staff, and the QMRPs. Thus, the composition of the disciplines that was in attendance at the Psychiatry	Noncompliance

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	individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Clinics would qualify as an IDT. The topic of the discussions at these Clinics was primarily focused on the effects of prescribed medications, as determined by the frequency of the monitored target behaviors, which the Psychologist presented. The discussion also included the subjective impressions of other team members, as well as the description of any medication side effects by the nursing staff. However, there was very little discussion of alternate treatment approaches, other than those related to the psychotropic medications, although there was discussion of environmental factors, and/or changes in physical status that may be affecting the frequency of the monitored behavior adversely. The Consulting Psychiatrist who was present during the review clearly took this information into account when making decisions. The other psychiatrist's clinics could not be observed, because he was on vacation. However, the review of his Clinic notes also suggested that he conducted his clinics in a similar manner. There was insufficient evidence in the records reviewed to show that there was an interdisciplinary, integrated process to determine if psychotropic medication was the "least intrusive" approach to the individual's presentation before the pharmacological approach was chosen over a less intrusive behavioral approach. For example, due to the limitations on the current psychiatry staffing/consultants, psychiatrists did not attend individuals' annual PSP meetings, or meetings at which addenda to the PSPs were being discussed. Based on the documentation reviewed, there was no forum at which a truly integrated interdisciplinary discussion occurred between psychiatry and all other relevant members of individuals' teams. The discussion above with regard to Section J.8 of the SA regarding the lack of integration of psychiatric and psychological services is also relevant to this provision, as is the discussion below with regard to Section J.13 of the SA.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable	This provision of the Settlement Agreement discusses the importance of carefully assessing the benefit of the utilization of specific psychotropic agents against the risks posed by the side effects of those medications, and doing so in light of other alternative strategies. The primary documentation of this process appeared in the Human Rights section of the record. This documentation consisted of only limited terminology to the effect that the benefits of the medication outweighed the risks and then a listing of the most commonly known side effects of the medication, without any indication of the likelihood of these side effects occurring, based on the published literature. An example, which was randomly selected from the sample, but was typical of the documentation found in the remainder of the sample, is the following excerpt from the HRC Review of BSP for Individual #252, dated 4/7/09:	Noncompliance

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	alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	*Program Summary (to include restrictive/intrusive components):* *Target Behaviors: Agitation, Aggression, Sleep Disturbance* *Psychotropic Medications: Lamictal, Haldol, Valium, Inderal, Ambien, Emergency Ativan Protocol. Side effect profiles are attached to the BSP.* *Behavioral Interventions: Reinforcement, redirection, anger management training, planned ignoring* *Justification: [Individual #252] has a history of psychotic behavior, aggression, and agitation related to his psychiatric diagnosis of Schizoaffective Disorder, Bipolar Type. These maladaptive behaviors limit his social and adaptive functioning and pose a danger to himself and to his peers. He has required psychiatric hospitalization due to aggression to peers.* *Less intrusive approaches previously attempted: informal redirection and reinforcement* *Risk vs. Risk Analysis: The BSP and psychotropic medications will assist [Individual #252] in managing his targeted behaviors, and will provide staff with the tools for consistent interventions. Without the medication, he will continue to exhibit aggression, agitation, and sleep disturbance, and may pose a danger to himself or his peers. Without the BSP, his behavior may pose a danger to himself or to his peers.* *Plan to remove restriction/intrusive component: The team will review the use of psychotropic medication monthly, and will use currently established behavioral criteria to determine progress or regression.* *By May 2010, Agitation will be exhibited 50% or fewer of times sampled for six consecutive reporting periods.* *By May 2010, Aggression will be exhibited at a frequency of 50 or fewer times per reporting period for six consecutive reporting periods.* *Criteria for Sleep Disturbance will be established after 90 days.* This documentation did not make any differentiation between the five daily psychotropic medications and the additional emergency medication, in terms of each medication's potential benefits and risks. The attached side effects sheets provided only a rudimentary listing of side effects that did not make reference to the probability of the occurrence of those side effects.	

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		The other location in the record where there was a discussion of risk versus benefits was in the Annual Medical Summary and Physical Examination. This occurred in the section entitled, "Discussion of Significant Problems." The following excerpt from the 3/22/10 Annual Medical Summary and Physical Examination for Individual #32 illustrated the terminology that was nearly identical in each individual's record: *Psychiatric Diagnoses (please see Psychiatric Problem List) include: Stereotypic Movement Disorder with aggression; Autistic Disorder; and Pervasive Developmental Disorder. [Individual #32] continues to do well on the Abilify and is followed by Psychiatry on a regular basis.* *1. During the physical examination, I discussed with him the benefits reasonably to be expected, as well as the side-effects and risks reasonably to be expected, from the Use of Abilify; other appropriate alternative treatments and the potential risks and Benefits associated with the alternative treatments; and the risks, benefits and potential consequences associated with not taking the psychotropic medication. I also explained the procedures to be followed; as listed in the Medical Policies and Practices for psychotropic medications 3/6/04, and their purposes for the use of Abilify.* *2. After reviewing the psychotropic medication this individual takes, it is my determination, with input from the Personal Support Team, that the benefits of the psychotropic medication outweigh its potential risks and side-effects; that the risks of [Individual #32's] targeted behaviors outweigh the potential risks and side-effects of the psychotropic medication; that the use of the psychotropic medication as an integral part of his treatment program is appropriate; and that the use of the psychotropic medication is the least restrictive, clinically appropriate intervention for this individual.* *3. After reviewing the psychotropic medication [Individual #32] takes, it is my Determination that if he is not treated with psychotropic medication, the target behaviors could present a serious danger to him, could present a serious danger to others, could significantly impair his functional capacity, and/or could significantly interfere with the ability of staff to care for him.* *4. I have assessed the general physical health of this person, taking into consideration timely physical examinations; timely and pertinent laboratory, etc., test results; the age and current physical status of this person; this person's non-psychiatric medical diagnoses and non-psychotropic medication; any potential drug-drug interactions of significance; any non-psychiatric medical conditions which might explain the current psychiatric symptoms; any potential side-effects of significance*	

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		of the listed psychotropic medication, etc., and find the following: *A. There is no known non-psychiatric medical reason why the listed psychotropic medication should not be used at this time in this person.* *B. There are no known non-psychiatric medical reasons why the listed psychotropic medication should not be used at this time in this person in its current TXDADS drug formulary, (or PDR) recommended dosage range.* *C. There are no known significant non-psychiatric factors which should be considered in regards to the use at this time of the listed psychotropic medication in this person.* With regard to the "discussion" of risk versus benefits, Individual #32 functioned in the Profound Range of ID/DD, and also was diagnosed with a Pervasive Developmental Disorder. In her 11/17/09 Psychiatric Clinic Note, the Consulting Psychiatrist stated: "Individual #32 is not able to articulate any subjective complaints." Thus, it was unlikely that this Individual could participate in, or benefit from, a discussion of the risks versus benefits of the psychotropic medications. The terminology in the 1/5/10 Annual Medical Summary/Physical Examination for Individual #81 contained similar paragraphs, with the exception of the name change. However, the concluding two paragraphs of this section were as follows: *Prolonged QTc segment secondary to psychotropic medications: Geodon was discontinued on 8/5/2008 due to a QTc of 480 ms. By 9/16/2008, the QTc segment shortened to 458 ms. On 11/3/2009 the QTc was again high at 491 ms. A follow-up EKG was ordered but I am not finding this in the record today for review. I will order an investigation and see if this study was completed and, if not, order another one. I will also bring this information to the attention of the Psychiatrist, Dr. Crowley, for his evaluation and recommendations.* *I would like to note that, while by definition he has a prolonged QTc of greater than 450 ms, his risk for developing torsades de pointes is decreased because he does not have any of the following: High-dose psychotropic medications, ECG abnormalities, electrolyte disturbances, hepatic disease, renal disease, stimulant drug use or heart disease. He has no concurrent use of other medications which are known to increase QTc segment.* The addition of these paragraphs documented that the physician was aware of the elevated QTc interval and that appropriate action was taken in terms of discontinuing the Geodon, which is a known cause of this cardiac side effect. The significance being that	

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		elevated QTc intervals above 500ms can put the individual at risk of developing a cardiac arrhythmia that could potentially be fatal. The purpose of discussing this example here is to point out that there were standard preceding paragraphs that addressed the presence or absence of risk that would have been an appropriate place to discuss this information. The fact that the author of this document chose to add two paragraphs at the end of this section rather that in the prior paragraphs that discuss risk suggests that those paragraphs represent standard terminology, which was replicated in this section of the Annual Medical Summary/Physical Examination for each individual who was receiving psychotropic medication.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	ABSSLC had developed a Polypharmacy Committee that met monthly to review those individuals whose psychotropic medication profiles were consistent with the definitions of polypharmacy. The meeting was referred to as the Psychotropic Polypharmacy Review Committee Meeting. Minutes of these meetings were available from the following dates: 5/3/10, 6/15/10, and 7/5/10. The following excerpt from the 7/5/10 minutes listed the individuals who would typically attend this meeting: *In Attendance: Dr. Chengson, Dr. Craig, Dr. Pritchard, Dr. Lowrimore, Dr. Crowley, Dr. Whitt, Dr. Knight, Amy Hodge, Psychiatry Assistant, Toni Wilson, RN, Paige Polston, RN, Shane McLoud, QMRP, Shana Carroll, Psychologist, and Stephen Vinson, Psychology Assistant.* The format for the meeting was a detailed review of one individual who was receiving psychotropic medication. There was evidence of input from many of those in attendance. The focus was clearly on investigating the history with regard to the past attempts to decrease existing medications, as well as discussion of the possibility of decreasing those that had not previously been challenged. The meeting minutes were prepared by the Pharm.D., and consisted of approximately three pages. The notes of these meetings identified the individuals by their initials and living unit. In two of the three monthly reviews, there was a discussion of attempting further decreases in psychotropic medication whereas in the other meeting the consensus appeared to be that the existing medications were appropriate. This individual recently had been admitted to the State Mental Hospital. Given the large number of individuals at ABSSLC who were receiving Psychotropic medication the discussion of one individual each month will likely not produce any significant change in the overall prescribing patterns with regard to the use of Polypharmacy with these agents. The Facility might want to consider re-evaluating the format of the Committee. The Psychiatry Department had extensive information regarding the use of polypharmacy at the ABSSLC. It would be useful if the minutes of these Meetings also contained statistical data for the ABSSLC population, so that the actual progress in	Noncompliance

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		reducing polypharmacy could be visually tracked on a monthly basis. Over time, the accumulation of this data would enable the Committee to document the progress toward meeting this provision of the Settlement Agreement. Additional documentation regarding polypharmacy resided in the quarterly "Drug Regimen Reviews" that were carried out by the Pharm.D. These reviews were detailed and provided useful feedback to both the Primary Care Physician and the Psychiatrist. The reviews were intended to be reviewed by the Psychiatrist for those individuals whose regimens met the criteria for polypharmacy. The format for these reports recently had been changed to conform to the format used at other Texas SSLCs. The prior form did not include a signature line for the Psychiatrist. Therefore, for purposes of this review, it is only possible to comment on the number of reviews of individuals that were defined as being prescribed polypharmacy that also utilized the new format. Those individuals for whom documentation of the psychiatrists' review was present included the following six individuals: Individual #23, Individual #388, Individual #518, Individual #327, Individual #154, and Individual #136. At the time of the next Facility review, it should be possible to determine the degree to which the Psychiatrist is reviewing the new form. However, there were no comments on these forms from the Psychiatrist relating to the comments of the Pharm.D. Comments from members of the nursing staff did routinely appear on these notes, which indicated a recognition of the comments and the action taken if necessary. The review of the sample of records described below with regard to Section J.13 indicated that Quarterly Reviews were current and had been completed quarterly for 32 of the 41 individuals reviewed. The individuals for whom quarterly reviews were not found included: Individual #260 (most recent 3/2/10); Individual #103 (gap between 7/31/09 and 11/15/10); Individual #490 (most recent 2/15/10); Individual #537 (most recent 1/10/10); Individual #300 (most recent 4/27/10); Individual #532 (most recent 2/15/10); Individual #11 (most recent 2/15/09); Individual #464 (gap between 6/30/09 and 1/15/10); Individual #379 (was admitted on in April 2010, and no review could be found). Thus, there was available documentation in the record to confirm that these evaluations had been performed quarterly for the last year, and were current for 78% of the study sample. These reviews were uniformly of a high standard. A review and tabulation of the Data Sheets prepared by the Pharm.D., which were contained in the individual "Health Risk Assessment Tool – Pharmacy" indicated the following frequency distribution with regard to individuals receiving polypharmacy.	

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		Number of Medications — Number of Individuals Three psychotropic medications: 49 Four psychotropic medications: 36 Five psychotropic medications: 16 Six psychotropic medications: 8 Seven psychotropic medications: 1 Eight psychotropic medications: 1 **Total Number of Individuals on Polypharmacy 111**	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The Settlement Agreement stipulates that the Monitoring of Side Effects Scale (MOSES) should be administered on a quarterly basis for individuals receiving psychotropic medication. To assess for compliance, a sample was selected of 18 percent of the individuals at ABSSLC who were receiving psychotropic medication during the on-site review of the Facility. The composition of the sample population is described in detail later in this report with regard to Section J.13 of the SA. A review of the medical records for those 41 individuals yielded documentation that a MOSES evaluation had been performed on a quarterly basis over the last year, and was current for all but the following seven individuals: Individual #216 (only MOSES for 6/14/10); Individual #252 (most recent exam 2/21/10); Individual #293 (most recent evaluation 2/18/10); Individual #115 (gap between 12/9/09 and 4/30/10); Individual #260 (gap between 7/8/09 and 3/3/10); Individual #310 (most recent 3/9/10; and Individual #103 (most recent 3/30/10). Thus, 83 percent of the sample met this provision of the Settlement Agreement. The Dyskinesia Identification System: Condensed User Scale (DISCUS) was also to be performed on a quarterly basis for all of the individuals who received antipsychotic medication. The sample of 19 percent of individuals who received psychotropic medication indicated that documentation of current and quarterly evaluations for the last year could be identified for 30 out of 41 individuals. They could not be found for the following 11 individuals: Individual #216 (only the exam for 9/14/09 was present); Individual #398 (only the exam from 3/30/10 was present); Individual #252 (most recent exam 2/21/10); Individual #398 (only the exam from 3/30/10 was present); Individual #518 (gap between 11/3/09 and 5/20/10); Individual #293 (most recent evaluation 2/18/10); Individual #154 (most recent 2/2/10); Individual #115 (gap from 12/9/09 to 4/30/10); Individual #260 (gap from 7/8/09 to 3/10/10); Individual #310 (most recent 3/9/10); and Individual #103 (most recent 3/29/10). Thus, 73 percent of the sample met these criteria. Although not required by the SA, the DISCUS and MOSES also were performed at ABSSLC for those individuals who are receiving Reglan. The rationale for this was that although	Noncompliance

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		Reglan is used to treat severe gastroesophageal reflux disease (GERD), it has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and also can produce extrapyramidal motor side effects. The sample for this analysis was constructed by obtaining a list of all individuals who were prescribed Reglan from the pharmacy. The individuals who also received psychotropic medication were deleted, and a copy of the DISCUS for the last year was requested for every third name (33%). This process produced a list of the following seven individuals: Individual #226, Individual #333, Individual #488, Individual #183, Individual #208, Individual #40, and Individual #359. The documentation that was provided by the ABSSLC in response to this request indicated that the MOSES had been performed quarterly and was current for two of the seven individuals (29%), including Individuals #226 and Individual #333. The status with regard to the others was as follows: Individuals #448 (most recent 2/9/09); Individual #183 (none present); Individual #40 (only 5/13/10 present); Individual #208 (only 7/2/10 present); and Individual #359 (only 6/10/10 present). The review of the corresponding documentation for the DISCUS Assessments indicated that the DISCUS was current and had been performed quarterly for one of the seven individuals (14%), including Individual #333. The status of the evaluations for the remaining six Individuals was as follows: Individual #226 (only 4/27/10 present); Individual #448 (only 5/19/09 present); Individual #183 (only 4/25/10 present); Individual #40 (only 5/13/10 present); Individual #208 (none present); and Individual #359 (only 7/2/10 present).	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how	This provision of the Settlement Agreement addresses three significant inter-related factors that are central to the appropriate use of psychotropic medication for individuals with ID/DD. These factors are the documentation of the validity of the psychiatric diagnosis, the relationship of that diagnosis to the behaviors that are identified as targets of the psychotropic medication, and the objective documentation that the medication has been effective for the disorder for which it was prescribed. In order to assess these factors, a random sample of 10 percent of the individuals who were on each Dr. Lowrimore's and Dr. Crowley's caseloads was selected. This sample included the following individuals: Individual #115, Individual #151, Individual #32, Individual #13, Individual #490, Individual #127, Individual #398, Individual #532, Individual #79, Individual #365, Individual #252, Individual #63, Individual #388, Individual #327, Individual #11, Individual #61, Individual #438, Individual #48, Individual #537, Individual #103, and Individual #136. An additional sample also was obtained that was not random. The selection process for this sample was based on factors such as: Number of psychotropic medications received, psychiatric profile, and/or their risk profile. The individuals selected on this basis were:	Noncompliance

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	this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	Individual #293, Individual #310, Individual #518, Individual #8, Individual #216, Individual #23, Individual #300, Individual #149, Individual #2, Individual #268, Individual #120, Individual #464, Individual #154, and Individual #331. The medical records of the following individuals (under the age of 16) were also reviewed: Individual #387, Individual #163, Individual #81, Individual #455, Individual #160, and Individual #260. The sections of the records for the above individuals that were requested were as follows: <u>*On-Site Monitor Request*</u> *1. Data record;* *2. Social History Evaluation;* *3. The PSP section;* *4. The Positive Behavior Support Plan section, including Addendums;* *5. Annual Medical Summary;* *6. Active Problem List;* *7. Inactive Problem List;* *8. Psychiatric Problem List;* *9. Hospital Admission section;* *10. Health Risk Assessment Rating – tool and team meeting sheet (only most recent);* *11. Psychiatry section;* *12. MOSES/DISCUS Side Effects Screening section (last year, if possible – otherwise nine months);* *13. Quarterly Drug Regimen Reviews;* *14. Neurology Consultation section;* *15. Any documentation and consultations regarding the use of pre-sedation medication (i.e., Treatment Plan, Guardian Approval, HRC Approval, etc.); and* *16. The Human Rights section.* The psychiatric files, which were kept in the Psychiatry Office and were not contained in the medical records, were also requested and reviewed. A description of the specific symptoms, which support and document the diagnosis of the individuals' psychiatric disorder, could be identified in the 12 of the 41 records (29%), including the following individuals: Individual #300, Individual #398, Individual #363, Individual #532, Individual #79, Individual #8, Individual #252, Individual #11, Individual #268, Individual #115, Individual #160, and Individual #163. These	

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		individuals tended to be higher functioning individuals with major Axis I Psychiatric Disorders, such as Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder. Although the symptoms of the disorder were not identified in the section containing the psychiatric diagnosis, there were enough descriptions of the overt symptoms of the disorder in the mental status examinations and other sections of the record to substantiate the diagnosis. However, this is not consistent with the requirements of the SA contained in Appendix B that requires that the psychiatric assessment/evaluation to specify this information. In these records as well as the other records that did not contain this information at all, this deficiency could be addressed by adding a section in the Psychiatry Evaluations that specifically lists the identified symptoms that support the psychiatric diagnosis. This would place this documentation in one easily identifiable location. This documentation could then be carried forward in the Psychiatry Clinic Notes and amended as changes occur. The individuals for whom documentation of symptoms that would justify the psychiatric diagnosis could not be substantiated tended to be individuals who had Severe-to-Profound levels of ID/DD, and who manifested symptoms that were identified as being present on a behavioral basis elsewhere in the record. A related issue was the lack of documentation linking the monitored target behavior to the identified symptoms of the psychiatric disorder. The primary behaviors that were monitored to assess the efficacy of psychotropic medication at the ABSSLC were aggression, self-injurious behavior (SIB), and agitation. The documentation in the records that provided the linkage between the psychiatric diagnosis and the occurrence of these behaviors was either lacking or insufficient in the entire sample reviewed (100%). A potential remedy for this issue would be to clearly state in the diagnostic section of the Psychiatric Evaluations and Psychiatry Notes how the symptoms of the diagnosis produce and/or contribute to the monitored behaviors in those cases where the identified target behavior is not clearly a specific symptom of the diagnosis. As noted above with regard to Section J.8, behaviors that were identified as target behaviors of the psychotropic medication also frequently were identified in the Functional Analysis and Behavioral Support Plan as being present on a learned-behavioral basis, representing a response to demand situations, and/or were used by the individual to escape or avoid a situation. An example of this type of documentation from the Behavior Support Plan for Individual #61, dated 6/29/10, was as follows: *Current Status:* *A. Target Behavior: Aggression, Disruptive Behavior and Self-Injurious Behavior*	

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		B. Medication: Clozaril *Consideration will be given to medication changes in relation to progression or Regression in the objectives. Possible side effects of the medication may be found as an attachment to this plan.* *C. Revision and Reason: Revised in conjunction with her Annual Personal Support Plan. Revisions include minor wording changes. The criteria for Aggression, Disruptive Behavior and Self-Injurious Behavior will be extended through the 2010 Behavior Support Plan. The weekly reinforcement trip with the Behavioral Services Team will be continued along with the plan for adjusting the criteria to encourage further progress. The Replacement Behavior Functional Activity Participation will be changed to Asking for Delay. The corresponding Fundamental Outcome will be changed to expressing preferences and making choices in everyday life (Choices).* *Behavior Assessment:* *A. Functional Assessment: A Functional Assessment Interview was completed with The form from O'Neill, R.E., Homer, R.H., Albin, R.W., Sprague, J.R., Storey, K., and Newton, J.S. (1997). "Functional assessment and program development for problem behavior: A practical handbook (2nd ed.)." Brooks/Cole: New York. Two home staff were interviewed, one from each daytime shift. The target behaviors typically serve as a means to escape tasks, such as self-care activities and attendance at the Activity Center. These behaviors also provide her with control over her environment and with a means of expressing frustration or displeasure. The Individual usually demonstrates aggression towards staff, rarely seeking out peers. Aggression is usually preceded by a blank stare or odd comments such as "No trip!" These behaviors are more likely to occur when staff ask her to do something she does not want to do. She is likely to exhibit these behaviors if a lot of demands are being placed on her after she has just gotten out of bed. At times, she also acts aggressively towards staff when peers are displaying target behaviors. These behaviors are less likely to occur if staff allow her a period of time in the morning to wake up, without placing excessive demands on her.* *B. Reinforce/Preference Assessment: This Individual is highly motivated by both Negative and positive attention from staff. She enjoys going on walks, shopping, eating at restaurants, watching television and attending athletic events.* The dual identification of the behavior as being both a target of the psychotropic medication(s) and being present on a behavioral basis did not occur in 11 of the 41 plans reviewed (27%), including in the records of the following individuals: Individual #2,	

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		Individual #115, Individual #127, Individual #48, Individual #300, Individual #398, Individual #365, Individual #532, Individual #79, Individual #11, and Individual #8. The following excerpt from the Behavior Support Plan for Individual #252, dated 4/29/10, provided an example that differentiates between behaviors that are related to a psychiatric diagnosis, from those that were thought to be present on a learned basis. *Behavior Assessment: [Individual #252]* *A. Functional Assessment: [Individual #252] has historically been diagnosed with Schizoaffective Disorder, Bipolar Type. This diagnosis and its symptoms have a significant impact on how he interacts with his environment.* *Functional Assessment Interview Form was completed on 3/6/10 by four staff who Have worked with him for more than a year. The verbal threats component of Agitation serves as a way for him to obtain tangible objects, and also as an escape behavior. He will make verbal threats to staff when they do not give him what he wants, particularly sodas. Agitation in the form of yelling and verbal threats seems to increase around the 2 p.m. shift change, as he perceives that the staff on the oncoming shift may give him his 3 p.m. soda early. He will make verbal threats to peers whenever they are bothering him or talking excessively. The psychotic-like behavior components of Agitation (talking to inanimate objects or about things that are not real) appear unrelated to any predictable pattern and appear to be related to his psychiatric diagnosis. Aggression is more likely to be exhibited when he is being served by unfamiliar staff, or when staff approach him too closely when he is agitated. He does not respond well to being touched, and often will react aggressively if he is touched without warning or when he is agitated. All of his target behaviors are more likely to occur if he is psychiatrically unstable, or unable to get his regular soda. However, at times he becomes agitated or aggressive with no discernable precursors.* The following excerpt from the Behavioral Support Plan of Individual #115 also illustrated the differentiation between target symptoms related to the psychiatric disorder, and those present on a behavioral basis. However, the symptoms of the psychiatric disorder were comingled with those present on a behavioral basis. Particularly to ease staff's understanding of the differences, it might be helpful to separate them. *Behavior Assessment: [Individual #115]* *Current Variables: [Individual #115] has a Behavior Support Plan that targets Disruptive Behavior (Behavior that disrupts of interferes with normal daily*	

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		routine, including hitting windows and walls; lifting, bounding, or overturning furniture.) Depressive Behavior Crying and/or withdrawing-showing no interest in things she usually enjoys (e.g., helping in the kitchen, coloring, doing puzzles.) Becoming irritable with others (yelling and being angry with no precursor). Refusal To Follow Instructions (Refusing to follow instructions that staff are giving in regards to her daily living tasks, including refusing to get out of bed, refusal to go to bed in time to get at least 6 hours of sleep, refusal to go with the nurse to get catheterized or any other medical treatment, and/or refusal to do training task after two verbal prompts), and Hallucinations stating or acting as if she is seeing and responding to things that are not actually in her environment – spiders, snakes, men crawling up her wall, cats, dogs, flies, and/or bugs). Her Replacement Behavior is Participation in Daily Tasks. In conjunction with her plan, the Individual receives Paxil, Wellbutrin XL, and Seroquel as psychotropic medications. Again, these individuals also tended to function at higher intellectual levels and were diagnosed with Major Axis I Psychiatric Disorders; whereas those that manifested behaviors that were described as being both related to the psychiatric disorder and present on a behavioral basis were those with Severe to Profound intellectual deficits who had identified target behaviors, such as Aggression and Self-Injury, that could not be easily linked to the identified psychiatric disorder and appeared to be present due to behavioral factors. It is, of course, conceivable that a behavior could be related to an underlying psychiatric disorder and also be effected by environmental and/or behavior factors. In those situations where there is evidence to support that the behaviors have both biological and behavioral etiologies, this distinction should be identified, documented, and verified. As with the identification of the symptoms that support the psychiatric diagnosis, once this process has been completed, the information can be carried forward in the records and modified as needed in the future. This process may also reveal that there are individuals for whom the psychiatric medication is being utilized primarily to suppress behaviors that are derived from and maintained by behavior-environmental factors. In those cases, the PST should reconsider the appropriateness of the continued use of those medications. As noted above, another important aspect of this provision relates to the effectiveness of the psychotropic medication. The behavioral data present in the sample of records reviewed lacked the sufficient information necessary for either the PST or an external reviewer to determine if the medications that were currently being utilized had been effective to a degree that justified their continued use. The sole exception to this observation was contained in the record of Individual #127. Although baseline data was not available in the record that was reviewed, there was sufficient empirical data to	

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		determine a dose-response to the prescribed medication (Risperidone), which confirmed the efficacy of the medication. It was noteworthy that this individual was receiving only one psychotropic medication, which greatly simplified the empirical substantiation of efficacy. There was also a sufficient amount between time at each dose change, which made it possible to clearly differentiate the response to differing dosages of Risperidone. A primary deficiency in all of the records reviewed was the lack of any baseline data that could be compared to the contemporary data to determine efficacy. In the context of this review, baseline data refers to the frequency of the monitored behavior for at least three months prior to the introduction of the medication, which can then be compared to the most recent three months of data after the medication is thought to be at a therapeutic level. Naturally, this process becomes mathematically much more complex when multiple medications are prescribed and/or multiple changes are made in close temporal proximity to each other. Another purpose of maintaining this type of detailed, longitudinal data is to remind the PST about the difficulty in determining the efficacy of the pharmacological interventions when multiple changes in psychotropic medications are implemented at the same time or in close proximity to each other. The Psychology Department, working in collaboration with the Psychiatry Department, should be able to construct data collection and reporting systems that make this type of analysis possible. Examples of effective strategies include graphs with phase lines that indicate the time of changes in psychotropic medications, as well as changes in behavioral interventions with the ongoing frequencies of the monitored behaviors. Tabular systems that carry forward the first three months of data following the introduction of the psychotropic medication and/or a change in dosage can also provide this information, but can be cumbersome to maintain.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the	The section of the medical record that contains the Informed Consents related to the use of psychotropic medications was reviewed for the entire sample of 41 individuals described above with regard to Section J.13. This review indicated a completion rate of 100%. The individuals' Legally Authorized Representative (LAR) had signed consent documentation for 25 individuals (59%). The Facility Director had signed the informed consent forms for the remaining individuals who did not have a Guardian of the Person. This review indicated that signed consent documentation was being obtained for all of the individuals residing at ABSSLC who were prescribed psychotropic medication. However, the Risk versus Benefits section in the records, as discussed above with regard to Section J.10, were so minimal and formulaic in nature that it was doubtful the information presented to the Guardian or Facility Director would have been sufficient to	Noncompliance

#	Provision	Assessment of Status	Compliance
	medications or restrictive procedures and shall identify associated risks.	provide a truly informed decision. Another deficiency was that the consent form was a blanket consent for all of the psychotropic medications that the individual was receiving, and brief side effect sheets for each medication were attached to the consent form. There was also no documentation of a specific dose range for the medications for which the LAR or Facility Director was approving. The implementation of the changes in the sections of the record related to the risk-benefit considerations in the use of psychotropic medication should make it possible to provide the necessary information to the LARs and Facility Director, so that they can make an informed decision regarding their approval for an individual's psychotropic medication.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The coordination of services between Psychiatry and Neurology was discussed during the 8/3/10 interview with the Consulting Psychiatrist, who indicated that the primary communication with the Neurologist was accomplished through the written consultation. She recalled directly speaking with the Neurologist on approximately three occasions in the last two years. The Consulting Psychiatrist also indicated that if the Neurologist was going to begin an anticonvulsant for a seizure disorder, the Psychiatry Department would be notified so that they could observe the individual for any clinical effects on their psychiatric presentation. A Neurology Consultation section could be identified in the records of 35 individuals reviewed in the sample of 41 (85%). This high degree of neurological involvement with the residents of ABSSLC likely relates to the fact that it was originally begun as a residential facility for individuals with epilepsy. The Neurology Notes uniformly listed the psychotropic medications that the individual was receiving, as well as the anticonvulsant medications. Thus, the Neurologist was aware of the psychotropic medications that were prescribed for all of the individuals in this sample who were seen for consultation. The Psychiatrists' signatures or initials could not be located on any of the Neurology Consultation Notes. This was a serious deficiency, as the primary identified means of communication between the two disciplines was described as being through Consultation Notes. A potential solution to this would be to add signature lines for both the Psychiatrist and the PCP to the Neurology Consultation forms in the same manner as they appear on the Pharm.D. Quarterly Review of Psychotropic Medication.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should develop, implement, and maintain a process to identify and document the specific symptoms that support the

psychiatric diagnosis of record.

2. Documentation should be implemented that will illustrate and confirm the link between symptoms of an identified psychiatric diagnosis and target behaviors, such as aggression, agitation, and self-injurious behavior.
3. Consideration should be given to integrating the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies.
4. For each individual prescribed psychotropic medication, if a specific behavior is listed as both being present on a behavioral basis and also as a target behavior of psychotropic medication, the rationale should be identified and documented.
5. The Facility should continue to develop and implement programs and procedures that will decrease the reliance on psychotropic medication to pre-sedate individuals for medical and dental procedures.
6. ABSSLC should continue its efforts to recruit additional psychiatrists on a full-time and/or contractual basis.
7. The discussion of the risk-benefit considerations should be expanded to address both the Legally Authorized Representative/Facility Director's consent documentation and the Human Rights Committee approval process in a manner that more fully articulates and considers the probability of the potential benefits of the medications, as well as any potential risks.
8. In addition, documentation of a specific dose range for the medications for which the LAR/Facility Director is approving should be included on the consent forms.
9. The Facility should continue its efforts to monitor and reduce polypharmacy with psychotropic medication.
10. The Facility should continue to implement its new system to ensure that the Quarterly Drug Regimen Reviews performed by the Pharm. D. are reviewed and responded to by the Primary Care Physician and the Psychiatrist.
11. Strategies should be implemented to ensure that the MOSES and DISCUS Side Effects Scales are performed for individuals prescribed psychotropic medication at the frequency required by the Settlement Agreement.
12. The existing data-collection system should be modified so that it can be utilized to document the efficacy of psychotropic medications in decreasing the frequency and intensity of the behaviors for which they are prescribed.
13. A system should be developed and implemented to document that the Psychiatrists are reviewing the Neurology Consultation Notes in a timely manner.
14. The Facility should continue and expand the QES Reviews to ensure that an adequate self-assessment process is in place to measure the degree to which the Psychiatry Department is meeting the provisions of the Settlement Agreement.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Section K Presentation, provided by Catherine Hennignton and Ron Manns; o Psychological and Behavioral Services Policy #008.1, dated 7/31/10; o Behavior Support Plans for: Individual #387, Individual #267, Individual #199, Individual #415, Individual #540, Individual #61, Individual #534, Individual #216, Individual #300, Individual #437, Individual #32, Individual #479, Individual #530, Individual #464, Individual #438, Individual #544, Individual #303, Individual #156, Individual #81, Individual #120, Individual #455, Individual #276, Individual #505, Individual #545, Individual #286, Individual #49, Individual #89, Individual #194, Individual #374, Individual #268, Individual #507, Individual #398, Individual #342, Individual #442, Individual #88, Individual #310, Individual #22, Individual #486, Individual #79, Individual #154, Individual #149, Individual #430, Individual #287, Individual #160, Individual #260, Individual #102, Individual #172, Individual #59, Individual #396, Individual #324, Individual #246, Individual #399, and Individual #357; o Psychological Update Reports for: Individual #415, Individual #517, Individual #61, Individual #43, Individual #4, Individual #303, Individual #455, Individual #505, Individual #49, Individual #398, Individual #313, Individual #310, Individual #486, Individual #149, Individual #287, Individual #396, Individual #324, and Individual #341; o Behavior Observation Notes and Scatter Plot Data Sheets for: Individual #415, Individual #61, Individual #398, Individual #310, and Individual #287; o Clinical Records (reviewed on-site) for: Individual #517, Individual #43, Individual #4, Individual #303, Individual #293, Individual #313, Individual #149, Individual #102, Individual #396, and Individual #324; o Behavior Support Committee (BSC) Meeting Minutes, from 1/5/10 through 6/29/10; o Outline describing ABSSLC Behavior Supports Committee; o Checklist for BSC Packets, dated 6/16/10; o Behavior Support Plan Self-Monitoring Checklist, dated 12/9/08; o Behavior Support Plan Review Checklist, dated 7/1/10; o Presentation to BSC, Joe Example, dated 6/22/10; o Behavior Support Plan Tracking Sheet and accompanying documentation for: Individual #123 (Psychological Update and Behavior Support Plan), Individual #4 (Psychological Update, Structural and Functional Assessment Report, and Behavior Support Plan), and Individual #439 (Psychological Update and Behavior Support Plan); o Completed Behavior Support Plan Review Checklists for: Individual #123, Individual #4, and Individual #439; o Structural and Functional Assessment Reports for: Individual #303, Individual #156, Individual #505, Individual #194, and Individual #486; o Safety Plans for: Individual #505, Individual #310, and Individual #486;

	○ Psychology Monthly Progress Notes for: Individual #534, Individual #546, Individual #194, and Individual #324; ○ Psychiatry Notes (six months) for: Individual #61, Individual #505, Individual #398, Individual #310, and Individual #287; ○ List of Individuals Identified with a Diagnosis of Pica, Missing or Absent Without Leave, Enhanced Staffing, and High Rates of Injury, since 1/1/10; ○ Unusual Incident Report for Individual #303, dated 6/26/10; ○ Behavior Protocol for Individual #310; ○ List of Individuals Receiving Counseling; ○ Individual Counseling Treatment Plans for: Individual #163, Individual #81, Individual #231, and Individual #396; ○ Organizational Chart for the Psychology Department, dated 7/10; ○ Psychology Department Staff Roster, dated 2/10; ○ Psychology Department Meeting Minutes, dated 2/19/10, 3/25/10, 5/6/10, and 6/16/10; ○ Plan for Professional Development for Psychologists, revised 8/10; ○ Functional Assessment Training Class: Handouts and Signature Sheet, dated 5/13/10 and 5/19/10; ○ Structural and Functional Assessment Study Groups: Agenda and Sign In Sheets, dated 6/3/10 and 6/9/10, 6/17/10 and 6/23/10; ○ Curriculum for New Employee Pre-service Training (NEPT) Positive Behavior Supports; ○ Memo to Laura Davis at the University of North Texas from Catherine Hennington, dated 8/3/10; ○ Description of the External Quality Review at ABSSLC Provided by JKP Analysts; ○ JKP Analysts Exit Report, dated 7/30/10; ○ Memo to Melissa Nosik from Ron Manns, dated 7/21/10; ○ Overview of Basic Behavior Supports Training, dated 7/29/10; ○ Curriculum Vitae for Joshua K. Pritchard, Board Certified Behavior Analyst (BCBA), and Melissa R. Nosik, Board Certified Behavior Analyst (BCBA); ○ List of Individuals Who Would Have a Monthly Progress Note in the Chart; ○ Information for Psychology Assistants, dated 5/7/10; ○ Data System description and accompanying data sheets (scatter plot for frequency and severity, simple frequency, and partial interval; ○ Antecedent/Behavior/Consequence (ABC) form; ○ Monthly Progress Review description; ○ Step-by-Step Instructions for Setting Up Monthly Progress Notes; and ○ Template for Psychology Monthly Progress Note ▪ **Interviews with**: ○ Catherine Hennington, Director of Psychology, and Ron Manns, Behavior Analyst, on 8/2/10; ○ Members of the Psychology Staff including: Joseph Abeyta, Victor Aguero, Mary Bone, Shana Carroll, Melissa Castillo, Stacy Dow, Stacia Ellison, Jason Fry, Jenni Jamison, Erin Lomasney, Benje Morrison, Connie Moss, Tiffany Neely, Michael Smith, Barbara Strelow,

	and Sarah St. Cyr, on 8/5/10; and o Direct Support Staff Member, on 8/6/10. ▪ **Observations of**: o Home 5961, Home 5962, Home 5971, Home 5972, Home 6330, Home 6350, Home 6360, Home 6370, Home 6390, Home 6400, Home 6450, Home 6460, Home 6500, Home 6510, Home 6690, Home 6700, Home 6710, Home 6720, Home 6730, Home 6740, Home 6750, and Home 6760; o Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6380; o Senior Center 5911, Senior Center 5912, and Senior Center 5913; o Workshop 680, Workshop 662, and Workshop 657; o Pool; o Incident Report Team Meeting, on 8/2/10; o Psychiatry Clinic, on 8/3/10; o Behavior Support Committee Meeting, on 8/4/10; o Weekly Personal Support Team Meeting, on 8/4/10; o Emergency Personal Support Team Meeting for Individual #293, on 8/2/10; o Personal Support Planning/Discharge Planning Meeting for Individual #58, on 8/3/10; o Personal Support Planning Meeting for Individual #303, on 8/5/10; o Human Rights Committee Meeting, on 8/3/10; and o Unit Meeting, on 8/4/10
	Facility Self-Assessment: The Facility's POI indicated overall that its self-assessment showed noncompliance with almost all of the requirements of this section of the SA. The areas in which compliance was noted was with regard to some of the qualifications and experience of the Director of Psychology, and the development of a plan to increase the numbers of BCBA qualified staff. This was consistent with the Monitoring Team's findings. During the Monitoring Team's visit, the Director of Psychology and the Behavior Analyst presented a review of the progress the Psychology Department had made towards meeting the requirements of the Settlement Agreement. While additional BCBA staff had not been hired, there was a significant increase in the number of staff scheduled to begin coursework leading to certification. The Director of Psychology remained enrolled and was making progress toward completion of the course of study. Additional training in Applied Behavior Analysis (ABA) also had been provided to members of the Psychology Department. Changes had been made to the Behavior Support Committee to improve its function as an internal peer review mechanism. Psychology staff responsible for Behavior Support Plans were present and received feedback from supervisors and peers regarding the quality of the plan. A checklist had been developed to help guide the process. The Facility also had contracted with two Board Certified Behavior Analysts to provide external peer review. These individuals had visited the Facility to provide feedback and training to staff.

	Revisions also had been made to the data collection system. Depending upon the target behavior, measures of frequency, percent occurrence (i.e., partial interval), and/or severity were identified. Staff were beginning to graphically present measures of individual target behaviors, allowing for clearer interpretation and analysis of treatment effectiveness. Monthly reviews of progress had been initiated. Staff had begun completing Structural and Functional Assessments for identified individuals. The plan was to complete these in time for the individual's annual review. Guidelines and training had been provided to members of the Psychology Department. Lastly, the curriculum for staff training in Positive Behavior Support had been revised and expanded. The Behavior Analyst also had been working with the QMRP department to develop a training program for educating individuals with developmental disabilities. Included in this training was introductory information regarding delivery of instructions, using prompts, implementing shaping and chaining strategies, and applying reinforcement contingent upon correct responding.
	Summary of Monitor's Assessment: Although the Facility had not been able to recruit additional Board Certified Behavior Analysts, there had been a significant increase in the number of staff pursuing this credential. Also of note was the increased training in Applied Behavior Analysis provided to psychology staff by both Facility personnel and external consultants. Improvements had been made to the peer review process, with changes in staffing and format of the Facility's Behavior Support Committee, and the hiring of external consultants. As the process is streamlined to ensure efficiency and effectiveness, staff will continue to learn new and improved strategies to help effect change and the individuals served will experience the benefit. Data systems had been improved in an effort to ensure more accurate measurement of identified problem behaviors. Systems for inter-observer agreement had yet to be developed, but the plan was to address this as staff became familiar with the new data collection forms. Guidelines for the completion of Structural and Functional Assessments had been developed and implementation had begun. Behavior Support Plans and accompanying Safety Plans remained a work in progress. There continued to be a need for greater emphasis being placed on the teaching of replacement behaviors, particularly functional communication skills, expanded antecedent strategies, and enriched reinforcement strategies. As noted previously, efforts will need to be made to ensure treatment integrity and staff competency.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Catherine Hennington and Ron Manns remained in their positions as Director of Psychology and Behavior Analyst, respectively. The Behavior Analyst remained the only BCBA qualified staff. The Director of Psychology continued to be enrolled and was making progress toward completion of the course of study. The Facility and the State DADS are to be commended for their efforts to recruit additional BCBA level staff. While these efforts had not resulted in an increase in staff trained in Applied Behavior Analysis, there had been a significant increase in staff interest in pursuing board certification in this area. Four members of the psychology staff had completed a minimum of one course, and an additional 11 were to begin coursework through the University of North Texas (UNT) in the Fall. This resulted in 14 of 19 Associate Psychology staff (73%) beginning a plan of professional development to pursue Board Certification. Tuition costs were paid by the State. In addition to providing support to staff to enroll in the course of study offered through UNT, all Associate Psychologists were provided copies of two texts on Applied Behavior Analysis. Further, the Behavior Analyst had provided initial training to staff on Structural and Functional Assessment. This training, held in May 2010, was attended by 17 of the 19 Associate Psychology staff. Two study groups also met over four days in June 2010, at which Applied Behavior Analysis topics were discussed. A total of 16 Associate Psychologists participated in one (11 staff) or both (five) of these groups. Lastly, changes had been made to the Behavior Support Committee that will allow for ongoing training in the development of Behavior Support Plans. This provision item was rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by this provision item as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the SA.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	Ms. Hennigan remains as Director of Psychology. She has served in this role since 1997. Ms. Hennigan's credentials include a Master's degree in Pre-Clinical and Counseling Psychology, and she is licensed in the state of Texas as a Psychology Associate. Although she is not a Board Certified Behavior Analyst, she provides an excellent model for her staff as she pursues this level of credentialing. The Director of Psychology appeared to be providing leadership to ensure that the psychological services at ABSSLC were improved and met the required standards. Previous reports of psychological and behavioral services staff (obtained during baseline reviews) reflected positive reviews of her interactions and support of staff. During the	Substantial Compliance

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		review in August 2010, there were no observations or reports that would suggest that this has changed since the initial baseline review.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	Important changes had been made to the Behavior Support Committee (BSC). Participants included the Director of Psychology, the Behavior Analyst, Associate Psychology staff, and the Director of Speech and Audiology Services. At the meeting held on 8/4/10, the Associate Psychologist responsible for the development of an individual's Behavior Support Plan, presented a review of the plan and related documents (i.e., Psychological Update, and in one case, Structural and Functional Assessment). A Checklist for BSC Packets had been developed to serve as a guide for staff. While it was good to observe a level of peer review as evidenced by discussion and feedback, a focus of the meeting should be on the content of the Behavior Support Plan with recommendations made based upon demonstration of improvement or worsening as reflected in graphic display of the data. Based on interview, a contract had been established with two Board Certified Behavior Analysts to provide external peer review. These consultants conducted one visit to the Facility in July, during which time they reviewed individual cases and provided oral and written feedback. Additionally, one of the consultants had provided training to Behavior Services Team staff as evidenced by an attachment to the training document. A total of nine staff received training in Basic Behavior Supports. The Facility is advised to establish a regular schedule of consultation to ensure ongoing external peer review.	Noncompliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and	Steps had been taken to improve the collection of data used to measure identified target behaviors. New data sheets had been distributed, allowing for measures of frequency, percent occurrence (e.g., partial interval), and/or severity of the response. As measures of severity can be particularly difficult to define, staff are directed to Iwata, Pace, Kissel, Nau, & Farber (1990) (complete references are provided at the end of the references section). Staff also were beginning to plot data separately for individual target behaviors, allowing for a clearer analysis of the efficacy of the treatment plan. Additionally, monthly progress notes had been introduced for 74 individuals. The Psychological Monthly Progress Note was reviewed for four individuals. More specifically: ▪ The note for Individual #534 provided a review of the monthly frequencies of identified problem behavior between 7/6/09 and 6/30/10. While data for two of six reported behaviors reflected "Unchanged trend for year," there were no recommendations made regarding changes to the Behavior Support Plan, and/or retraining of staff. ▪ A review of Individual #546 suggested improvement in his behavior over the past year. No changes were recommended.	Noncompliance

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<tr><td></td><td>revised promptly if target behaviors do not improve or have substantially changed.</td><td>

The Psychology Monthly Progress Note for Individual #194 reflected worsening of his “behavioral outbursts.” A note indicated his Behavior Support Plan would be revised at the time of his annual meeting scheduled to occur the following month. Specific recommended changes were not listed.
Finally, a Psychology Monthly Progress Note, dated 7/10, was provided for Individual #324. Although an increasing trend was noted for self-injury, aggression, and personal and chemical restraint, there were no recommendations made for changes to the Behavior Support Plan.

While monthly review of an individual’s progress is appropriate and necessary, it is equally essential to ensure that a follow-up analysis is completed when progress is not evident. If it is determined that the plan is not being implemented as designed (i.e., poor treatment integrity), staff should be provided further training, including on-the-job competency-based training. If the plan has been implemented with a high degree of integrity, then changes should be made to the plan accordingly. Documentation of steps taken in response to limited or no behavior change should be maintained in the individual’s record. It should be noted that Structural and Functional Assessments had been completed for Individual #194 and Individual #324. Information gained through these assessments may lead to changes in the Individuals’ respective Behavior Support Plans.
A comparison was made between Behavior Observation Notes and Scatter Plot data sheets for five individuals. While reliability was good in some cases, it was very poor in others. The table below summarizes the dates of data collection for identified target behaviors and occurrence agreement between information found in the Behavior Observation Notes and that found on the Scatter Plots for each of the five individuals.
<table>
<tr><th>Individual</th><th>Target Behaviors</th><th>Dates</th><th>Agreement</th></tr>
<tr><td>Individual #415</td><td>SIB</td><td>1/7/10 to 7/6/10</td><td>57%</td></tr>
<tr><td>Individual #61</td><td>Aggression</td><td>1/1/10 to 7/4/10</td><td>97%</td></tr>
<tr><td>Individual #398</td><td>Ingesting Fluids</td><td>1/3/10 to 7/3/10</td><td>88%</td></tr>
<tr><td>Individual #310</td><td>Aggression/Agitation/ Elopement/Impulsive/ SIB/Suicidal Threat</td><td>12/30/09 to 1/29/10; and 4/17/10 to 6/27/10</td><td>48%</td></tr>
<tr><td>Individual #287</td><td>Aggression/Elopement SIB</td><td>1/1/10 to 5/31/10; and 6/5/10 to 6/30/10</td><td>86%</td></tr>
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		While the changes in data collection will hopefully provide more information regarding the occurrence and non-occurrence of identified problem behaviors, it remains clear that measures of inter-observer agreement are an essential component of any data system. At the time of the monitoring visit, there was no plan in place for the assessment of inter-observer agreement with regard to the collected data.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	A template had been developed to serve as a guide for staff completing Structural and Functional Assessments. The psychology staff reported that 250 Individuals had Behavior Support Plans at the time of the visit. Further information provided indicated that a total of five Structural and Functional Assessments had been completed since 2/21/10. A sixth assessment was reviewed at the Behavior Support Committee meeting held on 8/4/10. A review of five of these assessments was completed. The reports included important information for understanding the steps that were taken to complete the assessment. Both indirect and direct methods of determining behavioral function were identified. When using indirect methodology, a description was provided of the staff involved with regard to their familiarity with the individual, both in terms of length of employment and shift worked. Tools used also were identified. These included the Questions About Behavioral Function, the Motivation Assessment Scale, and the Functional Assessment Interview Form. Summaries of staff responses were provided when rating scales were employed. The psychologist completing the assessment also indicated the dates of formal observation. Lastly, the reports included an in-depth review of the individual's past history. Elements that were missing from the reports included a narrative description of the psychologist's observations. Greater reporting with regard to information gathered through interview also would have been helpful. Staff should focus on the individual's communication abilities, his/her typical daily schedule of activities, and a clear indication of the method used to determine preferences. Less focus on information found in the individual's clinical record and greater emphasis on current assessment information would greatly enhance the reports. If analyses are completed that do not bear clear findings, simply summarizing the results would suffice. The goal is to produce a report that indicates the methods used, the information gathered, and the hypothesis developed regarding the function(s) of the target behavior. The following provides information about four of these assessments: ▪ Structural and Functional Assessment Report for Individual #156: o Assessment procedures included a review of Individual #156's records, including observation data, as well as rating scales and interviews completed with direct support professionals. Lacking was direct observation by the psychologist of the individual when he was	Noncompliance

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		experiencing problem behavior. o A brief summary of Individual #156's history was provided, along with summaries of his communication skills and interests. Staff should limit the history to very basic information, such as length of time the identified target behaviors have been present, responsiveness to intervention, and current placement information. For more in-depth information regarding the individual's past, the reader should be referred to the individual's record. A clear description of the individual's communication skills should be included, as should a summary of the individual's typical daily schedule, and identified preferences. o The target behaviors were defined clearly in the text and in table format. To avoid redundancy and increased length to the document, staff should choose only one format for presentation. o On page 2, the pattern of target behaviors was described. One statement was unclear: "This chain was described by staff as reliable in escalation through three stages, but not consistent in the behaviors exhibited during those stages." o One of the target behaviors was listed as: "Threatening Retaliation." Retaliation implies that the individual suffered some wrong at the hand of another. It may be more appropriate to simply label this, "Threatening Behavior." o Graphic display was improved when target behaviors were presented separately. o Extensive information was provided with regard to the individual's medical and psychiatric histories. Relevant medical and psychiatric histories should be limited in scope to those issues that are potential variables in the current situation. o Rather than repeating what was written in Behavior Observation Notes, the psychologist should summarize what he/she learned from the review. o The findings summarized in the conclusion section were quite informative. The psychologist clearly described the possible reinforcing potential of some of the interventions that were described in the Behavior Support Plan. Based on this assessment, greater thought should have been given to altering the plan to minimize this potential while increasing opportunities for active engagement and improved alternative responding. Specifically, the Personal Support Team should consider the following: 1. Develop a backup plan to be implemented when a previously scheduled, preferred activity is delayed or suddenly unavailable;	

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		2. Develop a reinforcement plan to be used when the individual appropriately terminates preferred activities, including returning to campus from a trip into the community; 3. Meet with medical staff to explore the possibility of regular administration of pain relief medication (e.g., Tylenol); 4. As problematic times of day were noted to be meals and change of shift at 2:00 p.m., schedule alternative activities at these times that will allow the individual to be appropriately engaged; 5. When presenting demands, offer the individual a choice whenever possible; 6. Teach the Individual a response that allows him to exit an environment when it becomes loud or disruptive; and 7. Ensure that consequences for targeted problem behaviors do not reinforce the very behaviors they are designed to reduce. For example, while many of the recommendations were appropriate based upon the information gained in the assessment, there remained a statement that staff should encourage a change of environment (an apparent reinforcer), if he did not cease the behavior when verbally prompted to do so. ○ Staff are also cautioned not to make generalizations about an individual's behavior based upon his/her diagnoses. The report suggested that due to his diagnoses, the individual was "predisposed to idiosyncratic responses to stimuli,… dependence upon routine, … and … difficulties with communication." While these may be included in the diagnostic criteria for a particular disorder, the author should describe the behaviors the individual displays as behavioral characteristics as individually specific. Not every person with a particular disorder displays all of the characteristics associated with that disorder. ▪ Structural and Functional Assessment Report for Individual #505: ○ A brief, but informative summary was provided in describing the purpose of the assessment. ○ Much valuable information, particularly regarding communication, was provided when the individual's attributes and interests were described. When making statements about the "feeling" the individual may obtain from wearing certain type of clothing, caution should be used. As the individual did not communicate verbally, any reference to his feelings likely would be purely speculative. ○ In the section entitled, "Challenging Behavior," there were a number of variables explored as possible contributing factors to the individual's self-injury. It appeared, however, that no firm conclusions could be drawn	

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		from the data that was gathered. The author simply should have provided a summary of his findings. o The primary function of a Structural and Functional Assessment is to gather current information to help develop a hypothesis regarding the purpose the target behavior serves for the individual. As such, greater emphasis should have been placed upon the information that was gathered through indirect and direct assessment methods. The Questions About Behavioral Function (QABF) was administered to four staff who represented two shifts. Although both aggression and self-injury were identified as problem behaviors, staff were instructed to complete the scale only for self-injury. The author noted that there was staff "consensus" regarding the function of aggression. It would have been advisable to have staff independently complete the rating scale for all identified problem behaviors. While the author indicated that Individual #505 had been observed on three different days, a narrative describing what had been observed was not provided. When direct observation takes place, it is advisable to review in as specific detail as possible what exactly was observed. A summary of one's findings can then be provided to support the hypothesized function of the behavior. o There was reference to the individual's "need" for a sensory diet and/or his beneficial response to the same. As noted in the report on page 6, the sensory diet was introduced at the same time that changes in medication were made. Yet later in the report, a statement was made that the "… data reflected in the historical monthly average graph does reflect a decrease in self-injury when a sensory diet was initiated." However, it is difficult to determine what intervention was responsible for any observed change, particularly as the author also noted increased time in restraint and increased participation in activities. The efficacy of sensory intervention activities has yet to be supported in the research literature (National Autism Center) and in some cases, negative effects have been observed (see Kay & Vyse, 2005). Given that it is not an evidence-based practice, caution should be used in attributing therapeutic benefit to the identified "sensory diet," although it is possible that the individual enjoys engaging in some of the included activities. To assess effectiveness of any intervention, objective and reliable data must be collected and analyzed. o Although staff reported that the individual was most likely to display aggression when staff intervened to protect him when he engaged in self-injury, a review of one entry in the Behavior Observation Notes suggested that this was not the case (i.e., page 18-19). In this instance, he transitioned to his room (presumably to escape a loud environment), aggressed toward staff when they followed him, and then tried to injure	

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		himself. This again highlighted the need for careful observation of the individual in his environment. o The individual's name was missing from the charts that provided a summary of the hypothesized function. o Recommendations provided at the end of the report offered several good suggestions, particularly as related to the development of expanded communication skills, follow-up regarding potential medical conditions, and avoidance of noisy and/or crowded environments. ▪ Structural and Functional Assessment Report for Individual #194: o Diagnostic information was provided in two sections of this report. Diagnostic information should be provided only once in the report to reduce redundancy and length. o Some inconsistencies were found in the report. At the bottom of page 1, it was noted that Individual #194 "… prefers to have staff help him complete" self-care skills, but in a table summarizing information from his PSP, it was noted that the individual likes to dress himself. Further discrepancies were noted between the definition of the target behavior found on page 2, and that found on page 6. Initially the behavior was defined as "Screaming or yelling, stomping his feet, spitting, or tearing at his clothing." Later in the document, the same behavior was defined as "Changing from content/happy to angry/upset and or tearing clothes, spitting, stomping feet and or screaming." o Behavior Observation Notes should have been summarized rather than repeating these verbatim. o The author provided a good summary of his observations. o Recommended changes to the Individual's Behavior Support Plan were most appropriate and reflected the information gained in the assessment. Specific recommendations included responding to Individual #194 by allowing him a break when he vocalized "No," teaching him a response to indicate he wanted help when a peer was bothering him, allowing him to sleep later so that he awakens just as breakfast is served, allowing him to shower on the evening shift, and exploring alternative clothing that may prove to be more comfortable. ▪ Structural and Functional Assessment Report for Individual #486: o The introduction provided in the purpose section was succinct yet informative. o When describing his personal attributes and interests, the skills Individual #486 displays were limited, and should have been expanded upon. Although he presented with many deficits, it would be helpful if the	

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		reader were informed of any strengths exhibited by the individual, particularly in the area of communication. o Data was reviewed related to the use of helmet restraint. Caution should have been used in interpreting this data as it may more accurately have reflected staff behavior than Individual #486's behavior. If the graph on page 3 entitled "Head Hitting," was going to continue to be used, it should be changed to "Frequency of Helmet Use," or something similar. To the staff's credit, a change was made in June of 2010 to more accurately reflect the occurrence of the target response. To better reflect the data that had been collected the graph should have been renamed (e.g., Percentage of Time Engaged in Head Hitting). The Y-axis also should have been re-labeled, "Percentage of 30 Minute Intervals During Which Head Hitting Occurred." o The author made an effort to determine whether restraint was more likely to occur when particular staff were working with Individual #486. To his credit, he noted that he was confounded in interpretation of this information, because time of day was also a factor. Consideration also should have been given to the amount of time each staff member worked with the individual, because this was also an important artifact of the data collected. o There was also concern that the author described other disabilities that had not been formally diagnosed. The author offered an opinion that Individual #486 displayed characteristics of Autism, suggesting that this might be an appropriate diagnosis. As the individual had not previously been diagnosed with this disorder, nor had a diagnostic evaluation been completed, this should not have been included in the report. Descriptions of observed patterns of behavior were (or could be) included in other sections of the report. o The author conducted several observations of the individual. A more in-depth description of what was observed (e.g., interactions with others, ongoing activity, noise level, responses of others to the target behavior, etc.) would have been helpful in developing a hypothesis with regard to the function of the behavior. o Several of the recommendations provided at the end of the report were appropriate in light of the information that was gathered. The author recommended that consideration be given to the diet provided to the individual, because he appeared to have clear preferences and strong dislikes of certain foods. Ongoing interventions to reduce discomfort due to allergies and digestive issues were also advised. The author also cautioned staff regarding the provision of preferred food (i.e., candy) contingent upon self-injury. However, concerns were raised when it was	

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		suggested that staff "… provide edible reinforcement for stopping head hitting following a prompt (page 14)." This may establish a chain of responding that could result in an increase in the rate of self-injury. A dense schedule of reinforcement for the absence of the behavior (differential reinforcement of other behavior) would be a more appropriate alternative. The following did not appear to have been considered, but should have been: 1) developing a schedule (presented to the individual in a visual format) in which other highly preferred activities/items are provided to the individual for appropriate termination of a van/car ride and the evening meal; 2) rather than reducing the duration of the individual's time at work (this was not noted as a problematic time or activity), develop an enriched and expanded schedule of activities; 3) a careful, data-based assessment of the effects of medication prescribed for the treatment of allergies and gastrointestinal problems should be completed as these may be contributing to the individual's discomfort; 4) psychology, speech/language, and direct support professionals should work collaboratively to help the Individual learn more adaptive ways to express himself; and 5) although preference assessments were reported to have been completed in the past, it would have been helpful to update this information with a current assessment. The Director of Psychology and Behavior Analyst had directed the psychology staff to complete these assessments as annual review dates came due. Consideration should be given to prioritizing the need for Structural and Functional Assessments. For example, as is discussed above with regard to Section C.7 of the SA, a number of individuals who had required the use of restraint more than three times in 30 days had not had such assessments completed. These and other individuals who present high-risk behaviors should be prioritized for completion of Structural and Functional Assessments.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Psychological Update reports for 18 individuals were reviewed. Thirteen of the 18 (72%) had been completed in the last year. Each report provided a brief description of the individual's background, followed by a summary of the individual's cognitive, adaptive, social, and affective functioning. It appeared that the summaries were based upon the psychologist's familiarity with, and observations of, the individual. This was followed by an in-depth review of the individual's behavior support plan and treatment for psychiatric issues. The date of the most recent psychological evaluation was noted in the summary. As outlined in the table below, only one of the 18 evaluations (6%) had been completed within the last five years.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Individual</th><th>Date of Update</th><th>Date of Last Evaluation</th></tr>
<tr><td>Individual #415</td><td>6/1/10</td><td>8/1/97</td></tr>
<tr><td>Individual #517</td><td>3/10/10</td><td>7/21/98</td></tr>
<tr><td>Individual #61</td><td>4/6/10</td><td>9/16/85</td></tr>
<tr><td>Individual #43</td><td>8/4/09</td><td>5/17/89</td></tr>
<tr><td>Individual #4</td><td>6/4/09</td><td>10/11/99</td></tr>
<tr><td>Individual #303</td><td>7/16/09</td><td>5/16/00</td></tr>
<tr><td>Individual #455</td><td>4/9/10</td><td>Spring of 2006</td></tr>
<tr><td>Individual #505</td><td>11/6/09</td><td>10/1/91</td></tr>
<tr><td>Individual #49</td><td>5/13/10</td><td>11/11/98</td></tr>
<tr><td>Individual #398</td><td>4/8/10</td><td>11/20/90 and 11/4/02*</td></tr>
<tr><td>Individual #313</td><td>10/21/09</td><td>5/17/96</td></tr>
<tr><td>Individual #310</td><td>7/2/09</td><td>8/26/93</td></tr>
<tr><td>Individual #486</td><td>7/15/10</td><td>11/16/87</td></tr>
<tr><td>Individual #149</td><td>7/7/09</td><td>4/12/95</td></tr>
<tr><td>Individual #287</td><td>3/4/10</td><td>11/3/89</td></tr>
<tr><td>Individual #396</td><td>3/3/10</td><td>1/5/88</td></tr>
<tr><td>Individual #324</td><td>3/23/10</td><td>1/30/01</td></tr>
<tr><td>Individual #341</td><td>8/9/07</td><td>11/25/96</td></tr>
</table>
*Assessments of cognitive and adaptive behavior respectively.

Information regarding psychological evaluations was found in other documents, including the Individual's Structural and Functional Assessment Report (Individual #194, last evaluation dated 1/2/87), Personal Support Plan (Individual #479, last evaluation dated 1/29/90; and Individual #260, last evaluation dated 8/31/07) and Clinical Record (Individual #276, last evaluation dated 7/7/05; and Individual #293, last evaluation dated 2/88).

Although these evaluations were clearly outdated and did not adhere to the policy of the Facility indicating that "each individual will have a current psychological evaluation," all but two reports (Individual #313 and Individual #149) included a statement suggesting that "… there does not appear to be any clinically significant changes in these functioning levels." One would hope that with effective training and intervention that the individuals served would have experienced change. Further, Individual #455 was school-aged at the time his report was completed. Evaluations are required every three years until the individual turns 21.
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<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month from the individual's admittance to</td><td>The records were reviewed of three Individual's admitted to the Facility since February 2010. Review of the Clinical Record for Individual #328 and Individual #401 revealed no psychological evaluation. The Personal Support Plan for Individual #102 indicated that</td><td>Noncompliance</td></tr>
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	a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	his last psychological evaluation was completed nearly two years prior to his admission. All of these individuals had been in residence for a minimum of two months. Plans will need to be put in place to ensure that newly admitted individuals receive a full psychological evaluation in adherence with the Facility's policy, and the requirements of the SA. As noted above with regard to Section K.6 of the SA, individuals had not been receiving timely psychological evaluations.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	The Facility identified 21 individuals who were receiving counseling services at the time of the visit. In every case, a licensed professional not employed by the Facility provided therapy. Individual Treatment Plans were provided for four of these 21 Individuals. Plans were designed to identify problems/symptoms, individualized goals to address each of these issues, and strategies employed to bring about change. Treatment goals and objectives were not measurable and often relied on subjective evaluation. For example: ▪ The treatment plan for Individual #163 included goals to "improve self-esteem" and "interact with peers and adults in a mutually respectful manner." ▪ Individual #396 had a goal to "alleviate depressed mood and return to previous level of functioning." Designing goals so that outcomes are stated in objective and measurable terms is necessary to allow for clearer assessment of progress, and efficacy of treatment.	Noncompliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP.	A total of 53 Behavior Support Plans were reviewed. This provision of the Settlement Agreement contains a number of different requirements, each of which is discussed in further detail below, specifically with regard to the quality of the PBSPs, the existence of plans for individuals who need them, and consent for the plans. <u>Quality of PBSPs</u> While most of the plans reviewed did not include a rationale for the selection of the proposed intervention or a detailed history of prior interventions and their related efficacy, this information was found in the five Structured and Functional Assessment Reports provided by the Facility. It may be appropriate to refer the reader to this document to obtain this information. The plans all contained a section in which medications were noted. Absent was any mention of medication provided to treat chronic or acute health care issues. This may prove helpful as idiosyncratic response to over-the-counter medication is not uncommon. Found consistently in all plans was standard language that indicated a	Noncompliance

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	Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	change in medication would be considered based upon progress or lack thereof in achieving identified behavioral objectives. A note was included that side-effects to medication could be found in an attachment to the plan, although attachments were most often missing. Healthcare issues were noted for several individuals. For example: ▪ Individual #544 was noted to suffer from a degenerative joint disease that could cause him pain. Staff were encouraged to ask about his pain should he demonstrate outward signs of discomfort. It was not clear that consideration had been given for administration of prophylactic pain medication for Individual #544. ▪ Individual #156 had knee pain identified as a "… primary setting event" for his engaging in identified problem behaviors. Staff were encouraged to query him about his pain level, and identifying pain was identified as a replacement behavior. Non-contingent and frequent query of pain level for Individual #156 might be more effective than responding to agitation with this response. ▪ Due to a medical condition, Individual #398 was placed on fluid restriction. He also was identified as taking medication that may increase his thirst. One of his targeted problem behaviors was identified as ingesting excessive fluids. Staff were advised to remind him of his restriction and review the times he could consume fluids. Staff should work together as an interdisciplinary team to develop a plan to better address the schedule of fluid intake for Individual #398. ▪ The information provided in the Behavior Support Plan for Individual #22 suggested that she may be in pain/discomfort during her menses. No further information was provided. It was not clear that consideration had been given for administration of prophylactic pain medication for Individual #22. Definitions for identified problem behaviors were included in every plan reviewed (100%). Less clear were the definitions of replacement behaviors. In approximately half of the plans, replacement behaviors related to discussing feelings with staff, engaging in appropriate conversation, or specifically asking for attention, a break, or a delay in the timing of an activity. Other plans were less clear. For example, some plans defined the replacement behavior as using one of a number of alternative communication systems to express one's wants or needs. In the section entitled "Behavior Assessment," a description was provided of the hypothesized function of the targeted problem behaviors. In many cases, interviews or behavior rating scales were named, respondents were identified, and date(s) of completion was provided. Some plans contained less than helpful information regarding the hypothesized function, rather the problem behavior was noted as a way for the individual to express his wants and needs, without identification of what these wants and	

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		needs were (e.g., Individual #387). In several plans, additional information was provided indicating situations in which the behavior(s) was least likely to occur. While reinforcers were identified in every case, it was unclear whether this information had been gathered through formal preference assessment or simply through interview with persons who were familiar with the individual. This should be clarified in future reports. It also would be helpful to specify more clearly the individual's preferences, if known. For example: ▪ Individual #415 was noted to like black-eyed peas and goldfish crackers in particular, but the type of music he liked best was not as clearly stated. ▪ Individual #540 was identified as preferring food and drink, but the type of food and drink was not made clear. ▪ In contrast, specific foods were noted for Individual #156, and even the types of chips were clearly identified for Individual #455. The more clearly one can determine the preferences of the individual, the better able the staff will be to help promote positive behavior change. Regularly scheduled preference assessments are strongly encouraged. As noted in the initial report, there were several concerns regarding the reliability of data. Review of the data reported as baseline suggested that measures of frequency of response were collected. However, in every case reviewed previously, it appeared that scatter plots were used to indicate the occurrence or non-occurrence of the behavior during half hour blocks of time. While the Facility has taken steps to change the data collection systems, the data collected prior to this change did not allow one to report on the number of times a behavior occurred, but rather the percentage of intervals during which the behavior was present. Future plans should be written to ensure accuracy of reported baseline data. It also may be more appropriate simply to report this as data from the previous year as rarely are true baseline conditions in place. Replacement behaviors were sometimes clearly related to the hypothesized function and clearly identified. Examples include: ▪ Individual #61 displayed aggression, the hypothesized function of which was escape; she was learning to ask for a delay in completing required activities; ▪ Individual #32 displayed aggression, the hypothesized function of which was escape from crowding; he was learning to ask for a break; ▪ Individual #89 displayed inappropriate vocalizations and self-injurious behavior, both of which were hypothesized to function as a means of escape; she was learning to ask for a break either to a quieter area or from engaging in an activity. At other times, however, the relationship between the hypothesized function and the	

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		replacement behavior were less clear. Furthermore, without an operational definition of the replacement behavior, it was unclear just what response the individual was going to exhibit to access the same reinforcement. Examples include: ▪ Individual #387 engaged in a number of problem behaviors "… as a means of communicating his wants and needs;" his replacement behavior was to use a variety of strategies "… to express his needs or wants appropriately;" ▪ Individual #415 displayed self-injurious behavior, hypothetically to escape pain and/or noise; his replacement behavior was learning to turn on a CD player; ▪ Individual #216 hit his head, hypothetically in an attempt to gain attention; his replacement behavior was to "participate in activities;" and ▪ Individual #486 hit his head, hypothetically to escape unwanted tasks, but also to continue with preferred activities; his replacement behavior was to "accept alternate sensory stimulation." One area that warranted increased attention in all plans was the scheduling of reinforcement. In several cases, there was no schedule of reinforcement identified (e.g., Individual #387, Individual #540, Individual #300, Individual #32, Individual #544, Individual #455, Individual #276, Individual #505, Individual #398, Individual #430, and Individual #246). In other cases, tokens were delivered on a daily basis, usually once per shift, and later exchanged on a designated day of the week (e.g., Individual #199, Individual #61, Individual #534, Individual #303, Individual #374, Individual #310, and Individual #396). In the case of Individual #374, there were two levels of reinforcement. If he earned a reduced number of tokens, he could access a trip, but it would be on campus. This same individual engaged in elopement behavior, indicating he accessed trips around the campus whether or not he had earned his tokens. Weekly access to a tangible or activity reinforcer provides a very thin schedule of reinforcement. Still others were provided attention once per shift for displaying appropriate behavior (e.g., Individual #199, Individual #534, Individual #300, and Individual #545). Again, this is a very thin schedule of reinforcement. A separate concern was raised for Individual #81. His plan called for a "Reinforcement Density Program." As described, the individual was to receive a visit from the psychologist or psychological assistant once during each daytime shift. If he was behaving appropriately, he could earn a token. Once a certain number of tokens were earned, he gained access to a prize box. This plan suggested that a member of the psychology staff was available seven days a week throughout the year. As with this or any token exchange program, it also would be appropriate to consider involving direct support professionals. Although some plans did identify reinforcement for identified replacement behavior, this constituted a teaching program to develop a new, alternative response for the individual. The Facility is encouraged to consider standard use of differential reinforcement strategies to ensure that the individual is accessing an enriched schedule of	

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		reinforcement throughout his/her day for the absence of the problem behavior(s), for demonstrating incompatible and/or alternative behavior(s), or for exhibiting increasingly lower rates of the problem behavior(s). The steps staff were to employ contingent upon the occurrence of problem behavior were similar across many plans. Guidelines suggested that the individual first be told to stop engaging in the behavior. If this was unsuccessful, staff were to physically intervene by redirecting the individual or guiding him/her to another area. What was particularly concerning was that if either or both of these steps did not result in the desired outcome, the individual was to be offered an activity or object, oftentimes one that had been identified as a reinforcer. Examples include: ▪ Individual #387 was to be provided music at the end of this sequence, if he continued to tantrum; ▪ Individual #540 was to be offered an environmental change, if aggression continued; ▪ Individual #438 was to be offered an environmental change and access to music, if his aggression did not stop, and a radio pillow at bedtime if he continued to engage in dangerous self-injury; ▪ Individual #505 was to be offered access to a bag that contained some of his favorite things, if he did not cease self-injury; ▪ Individual #89 was given the opportunity to move to a quieter environment, if she continued to engage in self-injury; and ▪ Individual #399 was provided access to preferred music, if she had been placing her fingers in her mouth, a component of her rumination definition. In each of these cases, the individual was gaining access to an identified preferred activity (e.g., being alone in a quiet environment, listening to music) or item (e.g., objects to manipulate). These contingencies could potentially reinforce the very behavior that has been identified as problematic. Only the Behavior Support Plan for Individual #486 (one out of 53, or 2%) identified the person responsible for monitoring the plan. As noted during the baseline visit, plans should include the signature of the person or persons responsible for its development. Equally important is an indication of the date of development. While the implementation date was noted on the first page, this information was provided in only 27 of the 53 cases (51%). <u>Existence of Plans for Individuals who Require Them</u> While touring the Facility and observing in homes, vocational areas, and activity centers, several individuals were observed engaging in disruptive behavior. For example, Individual #203, Individual #456, and Individual #80 were all observed engaging in self-injury as demonstrated by repeated hits. A request was made for copies of the Behavior	

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		Support Plans for each of these Individuals. Written response was provided that none of these Individuals required a Behavior Support Plan. The Psychological and Behavioral Services Policy clearly indicated that a Behavior Support Plan will be developed for "… all individuals who exhibit behaviors that constitute a risk to the health or safety of the individual… (p. 19)." The Facility should take steps to ensure that Behavior Support Plans are provided for all those in need. <u>Consent for PBSPs</u> Both the Behavior Support Committee and the Human Rights Committee (HRC) were scheduled to meet weekly. This allowed for frequent opportunity to obtain consent for changes made to Behavior Support Plans, and in the case of the HRC, approval of rights restrictions. Minutes from the Human Rights Committee Meetings held between 2/23/10 and 7/13/10 were reviewed. In the majority of cases, Behavior Support Plans were presented to the Committee for review due to changes in medication. There was little discussion regarding the content of the individual's Behavior Support Plan. Although the focus appeared to be on medication, medical personnel were present at only 70% of the meetings. A representation of the medical staff should be present when discussion focuses on medication matters. Parent and resident representatives were present at 65% of the meetings, and non-affiliated members were present at 85% of the meetings. One meeting was held with only three members present, the chairperson, a psychology assistant, and a non-affiliated member. As one purpose of a HRC is to ensure that practices are in accordance with community standards, a review should be completed with regard to membership and quorum criteria. Although most plans were approved with minimal discussion, the HRC chairperson, is to be commended for suggesting that a teaching program be developed to help Individual #305 learn to slow down while eating, so that he could once again enjoy a regular diet. An issue related to consent was raised during the Monitoring Team member's meeting with members of the Psychology Department. It appeared that all changes to a Behavior Support Plan require prior approval from the Behavior Support Committee and possibly the Human Rights Committee before the plan can be implemented. Further the Psychological and Behavioral Services Policy (i.e., Core Interventions, page 2) suggested that it was the responsibility of the psychologist to determine the complexity and restrictiveness of any Behavior Support Plan. A document describing both antecedent and consequence strategies, with their corresponding levels of restrictiveness, would be helpful in ensuring consistent identification of plan complexity. This also could be used to help guide decision-making regarding required consents. Those plans that incorporate changes to non- or minimally restrictive procedures should require approval through the internal peer review process, but not the Human Rights Committee. A hierarchy of restrictiveness would help expedite the review process ensuring that individuals' Behavior Support Plans are implemented and amended as needed in a timely	

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		manner.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The Plan of Improvement provided by the psychology staff indicated that changes had been made to data collection systems. This is discussed in further detail above with regard to Section K4 of the SA. Additionally, rates of target behaviors were being graphed individually, allowing for clearer visual analysis of change. Although the Psychology Department had introduced monthly review of progress, graphs continued to display monthly averages. As noted during the baseline tour, monthly averages can mask critical changes in behavior that result from changes in intervention, changes in medication, including subtle changes to dosing, and changes related to health issues. As recommended previously, graphing of daily measures of performance will allow for better analysis of efficacy of treatment. It will be critical to introduce a system for ensuring an assessment of inter-observer agreement. Psychology staff could begin to complete this assessment during daily visits to homes, activity centers, and vocational settings.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	During the tour, staff reported that Behavior Support Plans were clear as written. Greater attention to treatment integrity will be addressed in future visits to determine whether verbal report is consistent with staff implementation of plans. As additional plans have been developed to guide staff in behavioral crisis situations, a review was completed of three safety plans provided by the Facility. Feedback on each is provided below. ▪ The plan for Individual #505 was 15 pages long, the first seven pages of which consisted of a review of data, including graphs, and an analysis of risk. This was interesting background information, but not relevant to informing staff of the steps that should be taken in a crisis. The staff instructions, outlined in the next eight pages, proved to be quite confusing. These included guidelines for wrist-to-waist restraint (two pages), contingent glove restraint (two pages), non-contingent glove restraint (two pages), and chemical restraint (two pages). Throughout there was also reference made to a "sensory diet," with advice to staff to provide the identified activities (e.g., joint compression, weighted vest, etc.) even when the Individual was in restraint. Appropriately, staff were also advised that early release from restraint could occur for essential daily activities (e.g., meals, bathing, toileting). However, staff were also advised that the individual could be released for "… communication training, sensory gym, (and) any engagement in productive interaction with staff…" It is suggested that these guidelines leave far too much room for inconsistent applications of restraint, particularly in the case of "… productive engagement" as this is not clearly defined, and puts everyone at increased risk of injury. An additional concern	Noncompliance

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		was raised regarding the focus on a "sensory diet" because there is very little research to support its efficacy in helping to reduce problem behavior. Also of concern were the examples provided to help guide decision making with regard to chemical restraint. Criteria for many situations were extremely vague, including: a) "if anyone has an injury," but the level of injury was not defined (e.g., a small scratch); b) "if he cannot be redirected following numerous attempts," but it did not define how many attempts constituted numerous; c) "he will not calm," but no operational definition was provided of "calm"; and d) "injuries … could occur due to how long and violently he is fighting to remove restraints," but the length of time was not defined, nor was " violent." While it is understood that the situation may be very serious in nature, it is important that guidelines for staff be clearly and succinctly stated so that they are able to follow these in a time of crisis. While the monitor of the plan was identified, the date of the plan was not. ▪ The plan for Individual #310 was more clearly written. Again the plan was a bit long (i.e., six pages), with the first half of the plan consisting of a brief historical review, risk assessment, and guidelines for determining effectiveness. The guidelines for staff included several appropriate steps to take to avoid restraint (e.g., don't crowd the individual, switch staff), but it also advised staff to "… give in" at times. This is concerning as such intermittent reinforcement will most likely result in a strengthening of the aggressive and/or self-injurious behavior. Similarly the guidelines to follow when restraint was applied included some appropriate and useful measures (e.g., ensure limited attention to the individual by having those not involved in restraint leave the area), but also advised staff to tell the individual, "This is serious, this is not a game…." This was a concern because it may provide attention at a time when attention and verbal interactions should be minimized. Again, the monitor was identified, but the date of the plan was not. ▪ The plan for Individual #486 followed a similar format. Staff instructions were provided on the last two pages of this five-page document. The recommendations made to avoid restraint were similar to those found in the plan for Individual #310. While guidelines to remain calm, avoid crowding, and use non-threatening communication were all appropriate, "giving in" again raised concerns regarding the potential for reinforcement of the problem behavior. As this plan involved the use of a helmet, staff were advised to remove the helmet following a request to do so by the individual. If he then continued to hit his head, the helmet was to be reapplied. Repeated applications of the helmet while an Individual is agitated may increase the risk of injury. Response to communication was an important goal, but a criterion for release from the helmet may be appropriate in this case. This plan identified the monitor and the date of implementation, although it was noted to be a draft.	

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		In each case, a note was made that staff, including substitute staff, would be "authorized to implement" the plan only after they had completed competency-based training. As these were very elaborate plans (particularly the plan for Individual #505), it will be important to follow these guidelines that require competency-based training. Consideration also should be given to creating an abbreviated version of the plan as a quick reference guide for staff.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	At the time of the visit, competency-based training was not being implemented. Direct support professionals reported that psychology staff were present, helpful, and took steps to ensure that Behavior Support Plans were fully understood. An attachment to the Behavior Support Plan for Individual #287 documented the names of staff who had attended training provided by the Individual's Associate Psychologist and Psychology Assistant. A total of 18 staff, representing both home and activity center personnel, were trained. It appeared, however, that only four of these staff members had demonstrated competency by verbally describing the plan, which would only be the first step in demonstrating competency. No level of competency was indicated for the remaining 14 staff members. As reported following the baseline tour, competency-based training involves not only an indication of understanding, but also a demonstration of mastery as documented through on-the-job performance. By introducing a monitoring tool to assess treatment integrity, the psychology staff would be able to simultaneously assess staff competency in implementing the treatment plans for the individuals served (see Codding, Feinberg, Dunn, & Pace, 2005).	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the monitoring visit, the Facility employed a Chief Psychologist, one Board Certified Behavior Analyst, 19 Associate Psychologists (seven at level V, 12 at level III), and 10 Psychology Assistants. There was one vacancy each for a level III Associate Psychologist and a Psychology Assistant. The Facility was providing services to 452 individuals. The number of Associate Psychologists exceeded the ratio identified in the Settlement Agreement, with a ratio of 1:24. However, as noted with regard to Section K.1 of the SA, this provision has been rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by the SA as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. None of these professionals had the credentials required (i.e., BCBA). However, as noted in Section K.1, 14 of the 19 Associate Psychologists, as well as the Chief Psychologist, were registered for the Fall semester at	Noncompliance

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		the University of North Texas. The ratio of Psychology Assistant to Associate Psychologist adhered to the standard established in the Settlement Agreement, with one assistant being available for every two Associate Psychologists.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. As noted, the State is commended for providing tuition support for coursework through UNT at the time of registration. Consideration of additional incentives upon completion of certification is recommended to ensure continued tenure of psychology staff. Consideration should also be given to providing support to Psychology Assistants who have completed an undergraduate degree and who have expressed an interest in pursuing certification as Board Certified Assistant Behavior Analysts (BCABAs).
2. The Facility should establish a monthly schedule of visits by the recently hired BCBA consultants. Associate Psychologists could present their more challenging cases, resulting in expanded feedback and sharing of ideas for improved treatment.
3. Consideration should be given to the completion of Structural and Functional Assessments based upon the need of the individual. After conferring with supervisors, Associate Psychology staff should develop a plan for completion of a minimum of one assessment per month over the next 12 months. Individuals who are in crisis (e.g., those experiencing multiple restraints), or those who are not responding well to treatment intervention should be given priority.
4. Consideration also should be given to revising the Structural and Functional Assessment format. The current format incorporates a wealth of information that can be found elsewhere in the Individual's record. This document should focus on the information that is gathered through indirect, direct, and when implemented, analytic methodology. This will help the reader understand how the hypothesis regarding function was determined and will help clarify the rationale for the interventions included in the behavior support plan. It will also enable greater collaboration between speech/language and psychology staff in identifying and teaching true replacement behaviors.
5. Some specific changes that should be considered with regard to Structural and Functional Assessments include:
    a. Staff should limit the history to very basic information, such as length of time the identified target behaviors have been present, responsiveness to intervention, and current placement information. For more in-depth information regarding the individual's past, the reader should be referred to the individual's record. A clear description of the individual's communication skills should be included, as should a summary of the individual's typical daily schedule, and identified preferences.
    b. To avoid redundancy and increased length to the document, staff should choose only one format for presentation of target behaviors, either in the text or in table format.
    c. Relevant medical and psychiatric histories should be limited in scope to those issues that are potential variables in the current situation.
    d. Rather than repeating what was written in Behavior Observation Notes, the psychologist is encouraged to should summarize what he/she learned from the review.
    e. Diagnostic information should be provided only once in the report to reduce redundancy and length.
6. Clear behavioral objectives should be identified whenever a person receives therapy or support services in addition to their Behavior Support Plan. Objective measures of anticipated behavior change should be collected with accompanying data analysis to determine the effectiveness or lack thereof of the recommended practice.
7. With the introduction of new data systems, meetings should be held periodically with the direct support professionals to obtain information about the usefulness of these systems and staff confidence in collecting the required information.

8. Staff should present daily rates of targeted problem behaviors to better understand the efficacy, or lack thereof, of any intervention. Further, changes should be made to Behavior Support Plans when monthly review of progress indicates no improvement to targeted problem behaviors.
9. A system should be developed and implemented to collect measures of inter-observer agreement. Once a system is in place and operational for assessing the reliability of data, consideration should be given to reducing the redundancy of the current system. For example, it may be possible to limit Behavior Observation Notes to those incidents that meet specific criteria or that are unusual for the individual involved.
10. Behavior Support Plans should be developed with greater emphasis placed on:
    a. The teaching of replacement behaviors, particularly functional communication skills, expanded antecedent strategies, and enriched reinforcement strategies;
    b. Introducing dense schedules of differential reinforcement, be it reinforcement for the absence of identified problem behaviors, reinforcement for alternative and/or incompatible behaviors, or reinforcement for lower rates of identified problem behaviors; and
    c. An evaluation of the consequences that are applied contingent upon problem behaviors. While the Psychological and Behavioral Policy noted that aversive or punishment contingencies would not be employed, the policy also referred to the use of appropriate target behavior reduction strategies (page 4, paragraph #13c). Consideration should be given to the array of strategies that can be used to reduce the occurrence of problem behaviors (refer to Cooper, Heron, & Heward, 2007), but are neither noxious nor painful. Many of these strategies are widely accepted (e.g., loss of privileges, time out) and can be highly effective in bringing about positive behavior change.
11. A document describing both antecedent and consequence strategies, with their corresponding levels of restrictiveness, should be developed to ensure consistent identification of plan complexity, and guidance regarding both the consents required and the approvals needed. Those plans that incorporate changes to non- or minimally restrictive procedures should require approval through the internal peer review process, but not the Human Rights Committee. A hierarchy of restrictiveness would help expedite the review process ensuring that individuals' Behavior Support Plans are implemented and amended as needed in a timely manner.
12. Staff also should refer to graphically presented data whenever a review is conducted for an individual. Staff should not rely on recall to help guide treatment decisions. As the Facility continues to improve data collection systems, it will be important to bring about a corresponding change in the decision-making process.
13. As BSPs are developed, and as part of the peer review process, careful consideration should be given to ensuring that responses to behaviors do not result in strengthening the behavior, by for example, reinforcing the individual by providing them with what has been identified to be the function of the behavior. This will require strong emphasis on replacement behaviors and antecedent strategies. For example, instead of waiting to remove a person engaging in SIB from a loud environment, when the function of the behavior has been identified as escaping from such environments, the BSP should focus on removing the individual before the problem behavior occurs, and helping him/her develop a communicative response that signals a desire to change environments.
14. Consideration should be given to developing an abbreviated version of the Behavior Support Plan that can serve as a quick reference for all staff.
15. The initial training in Positive Behavior Support that is provided to staff should be greatly expanded. A more in-depth review of all of the following areas should be provided: possible functions of problem behavior, identification and teaching of replacement behavior, identification and application of reinforcement, antecedent strategies, and interventions that can be applied contingent upon the target behavior.
16. As is recommended above with regard to Section E of the SA, the Facility should consider focusing on making substantial changes in one residence or unit at a time. This would ensure that concentrated efforts among all disciplines could be devoted to the change process to ensure success. This would require prioritization of the need for changes to be made, particularly changes that impact the health and/or safety of individuals. It also would require planning to ensure that once the mechanisms for making the changes are established that there be expedient roll-out of the change process to other homes or units.

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SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC DNR list, updated 6/30/10; o Procedures for Rescinding a "Do Not Resuscitate Order" (DNR) ABSSLC, dated 6/25/10; o Texas Department of Health Standard Out-of-Hospital Do-Not-Resuscitate Order; o Abilene State Supported Living Center Death/Discharge Summary; o Quality Improvement Death Review of Nursing Services; o List of deaths with cause from 2/3/10 through 6/30/10; o Death Reports Still to be Completed from 10/11/09 through 7/17/10; o January to June 2010, Pneumonia Listing: Aspiration pneumonia, Pneumonia; o Pneumonia Tracking (Avatar) for the following individuals: Individual #386 on 1/2/10, Individual #338 on 1/3/10, Individual #55 on 1/8/10, Individual #187 on 1/9/10, Individual #186 on 1/11/10, Individual #289 on 2/2/10, Individual #348 on 2/8/10, Individual #199 on 2/8/10, Individual #392 on 2/17/10, Individual #9 on 2/18/10, Individual #229 on 2/19/10, Individual #114 on 2/23/10, Individual #216 on 2/24/10, Individual #7 on 2/28/10, Individual #228 on 2/28/10, Individual #285 on 3/1/10, Individual #285 on 3/19/10, Individual #75 on 3/3/10, Individual #531 on 3/19/10, Individual #403 on 3/20/10, Individual # 90 on 3/21/10, Individual #317 on 3/23/10, Individual #431 on 3/24/10, Individual #499 on 3/27/10, Individual #241 on 3/31/10, Individual #86 on 4/15/10, Individual #475 on 4/19/10, Individual #7 on 4/24/10, Individual #469 on 4/28/10, Individual #466 on 4/9/10, Individual #331 on 5/2/10, Individual #294 on 5/4/10, Individual #536 on 5/6/10, Individual #175 on 5/9/10, Individual #270 on 5/10/10, Individual #492 on 5/17/10, Individual #511 on 5/18/10, Individual #488 on 5/20/10, Individual #357 on 5/21/10, Individual #361 on 5/21/10, Individual #281 on 5/21/10, Individual #10 on 5/22/10, Individual #71 on 5/22/10, Individual #85 on 5/30/10, Individual #241 on 6/3/10, Individual #492 on 6/4/10, Individual #531 on 6/6/10, Individual #174 on 6/16/10, Individual #208 on 6/19/10, Individual #294 on 6/23/10, and Individual #6 on 6/30/10; o Cervical Cancer Risk Estimate; o ABSSLC Policy on Periodic Cervical Cancer Screening; o Post Exposure Injury Policy, revised April 2010; o Clinical Death Review Committee Reports for Individual #445, Individual #28, Individual #161, Individual #249, Individual #173, Individual #372, and Individual #419; o Medical records for the following individuals: Individual #100, Individual #431, Individual #281, Individual #10, Individual #59, Individual #282, Individual #208, Individual #361, Individual #331, Individual #134, Individual #62, Individual #322, Individual #458, Individual #357, Individual #317, Individual #511, Individual #294, Individual #492, Individual #311, Individual #20, Individual #145, Individual #241, and Individual #531; o Progress notes and orders for rescinding DNR orders for: Individual #213, and Individual #232;

	○ Infirmary Shift Report, dated 8/3/10, and 8/4/10; ○ Records Verification Checklist for Hospitalizations; ○ Revised Medical Emergency Response policy, dated 7/21/10; ○ Revised Medical Emergency Drill Checklist; ○ ABSSLC's Mock Medical Emergency Drills (161) February through June 2010; and ○ ABSSLC's training rosters ▪ **Interviews with**: ○ Richard Chengson, MD, Medical Director; ○ Edward Craig, MD, Staff Physician; ○ Stephen Pritchard, MD, Staff Physician; ○ Theresa Whitt, MD, Staff Physician; and ○ Jim Kluza, RN, BA, Chief Nurse Executive ▪ **Observations of:** ○ The following individuals: Individual #59, Individual #199, Individual #511, Individual #100, Individual #457, Individual #27, Individual #377, Individual #409, Individual #454, and Individual #101; and ○ Use of emergency equipment at building 6521 and the Infirmary
	Facility Self-Assessment: The Medical Department was anticipating hiring a fourth physician, which would allow the Medical Director to devote most of his time to medical administrative needs. The Medical Department, according to the Facility's POI, was aware of the lack of compliance with most aspects of medical care. This was consistent with the findings of the Monitoring Team. There had been some progress made in the area of policy and procedure concerning rescinding the DNR order, as well as screening the need for a pap smear.
	Summary of Monitor's Assessment: The Medical Department had been hampered by a lack of a full complement of PCPs. There had been attentiveness to such areas as the annual history and physical examination, as well as administration of vaccinations. There also appeared to be good up-to-date treatment of acute care illness. However what was most lacking was the aggressive diagnostic work-up and treatment to prevent repeat occurrences of such problems as aspiration pneumonia, GERD, frequent vomiting, chronic constipation, etc. To overcome this obstacle, the Medical Director needs to create clinical pathways and guidelines providing the next steps in the evaluation process, as well as a timeline. This timeline is perhaps what is most lacking. After each aspiration pneumonia or pneumonia diagnosis, there should be a thorough evaluation and provision of treatment to prevent the next occurrence. Such guidelines will standardize the work-up and the timeframe of that work-up across the campus. Clinical pathways were needed for dysphagia, GERD, aspiration pneumonia, pica, chronic constipation, fracture prevention, repeated vomiting, weight loss, etc. At the time of the review, current DNR orders needed to be reviewed by the PCP and PST to determine if they remained appropriate, if the qualifying condition needed revision in order for the DNR to remain, or whether the DNR no longer applied and should be rescinded. The State Office needed to provide guidance

	in how to interpret the qualifying condition in the context of the ID/DD population at ABSSLC. Ethics Committee members needed to be trained on the legal and ethical aspects of end of life decisions, including the DNR option. Mortality reviews have the ability to be highly educational with many recommendations, often with one or more of such recommendations for each department on campus. Yet, the ABSSLC Clinical Mortality Review Committee repeatedly had no recommendations. There may be some concern that there is increased liability or discoverability when reviewing such cases. If so, it is unfortunate that this has had such a negative impact on mortality review system at ABSSLC. Individuals' lives would be improved if the process allowed for critical review, and lessons learned could be applied to others. To ensure adequate quality improvement processes, mortality review committee minutes needed to be protected as peer review documents, and protected from discovery. The State Office needs to consider ways for this to be ensured. In addition, the mortality review process needs to occur in a more timely manner, and may best be conducted by a two-tier approach, a short medically focused review, and a later lengthy interdisciplinary review.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, Do Not Resuscitate Orders, mortality reviews, acute and preventative care, routine care, and emergency medical drills. Additional information regarding medical care is found below in the sections addressing Section L.4 of the SA. <u>Staffing</u> The Medical Department had a Medical Director, and four full-time staff physicians. It was anticipated that an additional full-time staff physician would be joining the department in September 2010. Additionally, there was a full-time nurse practitioner. There were two vacancies for psychiatry. The Medical Director was assigned two homes as PCP, which totaled about 61 individuals. The caseload was three homes until recently when another PCP was assigned the third home. Additionally, the Medical Director took on-call coverage. There were part-time contractual physicians hired to complete the annual medical evaluations. They also had assisted in completing the death summaries. Each primary care practitioner had a full caseload. It helped to have dictation capabilities available, making more efficient use of the time available to these professionals. It also translated into better communication as typed	Noncompliance

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		entries were more legible and more information could be transferred in the same amount of time compared to a hand written note. For improved communication, a dictation system also had been valuable in recording the PCP review of outside consultant reports, including a description of whether they agreed with the recommendations or had an alternative approach and reason to justify that option. The dictation system also allowed for rapid recording of any telephone conversations with consultant physicians or an individual's guardian or next-of-kin. Overall, the dictation system should continue to add to improved communication between the Medical Department and all other departments. Every business weekday, there were rounds in the Infirmary. Most PCPs had one or more individuals in the Infirmary at any one time. Additionally, the nurse liaison to the hospital also frequently joined the rounds. These were the most critically ill individuals, and the rounds were a forum to share clinical information with all the physicians in case covering physicians were to be called for an after hours problem. However, there did not seem to be any daily review of physician caseloads, and the problems that arose within the prior twenty-four hours. As is discussed in further detail above with regard to Section G.1 of the SA, such daily review would help to ensure the adequate integration of medical supports being provided to individuals at ABSSLC. Such meetings allow opportunities for all physicians to share ideas on a variety of clinical issues, as well keeping the Medical Director updated concerning the entire population. It also would allow the Medical Director to provide open and consistent guidance in clinical areas. Pharmacy and nursing staff should be invited to participate, depending on the availability of staff in those departments. They also would benefit from being updated and learning of the clinical problems, but also learning about such problems from the physicians' perspective. This is an important area of communication that is needed at the Facility. Minutes should be taken and recorded. <u>Do Not Resuscitate Orders</u> At the time of the last monitoring visit, 61 individuals had DNR orders. This represented approximately 13 percent of the total population of 465 individuals served at the Facility. Records of a portion of these individuals were reviewed and revealed that those without terminal illness had DNRs in place, as well as individuals who did not have guardians and who did not appear to be able to make informed decision about medical care. It appeared that the State had regulations that allowed guardians to put DNRs in place for individuals with developmental disabilities without petitioning the court. The regulations also appeared to allow two physicians to put a DNR order in place. It was unclear if this was the method used to institute DNRs for a portion of the individuals with DNRs at ABSSLC, and if so, if it was the Facility's physicians who approved the DNRs. If the Facility physicians were approving DNRs, this raised a conflict of interest issue, as	

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		well as complex ethical issues. During the August 2010 monitoring visit, there were 64 individuals with DNR orders, from the DNR list updated 6/30/10. There was one individual listed twice on the list, Individual #157. In comparison with other facilities across the country, facilities generally only have a few individuals with orders for DNR at any one time. This would suggest that ABSSLC may be over-interpreting the intent and indications for instituting DNR orders, and may need guidance with this issue. The Medical Director stated there was no updated policy concerning the matter of instituting DNRs. It would require going through the state attorney. However, it appeared that decisions regarding DNRs could be made at the local level, and relied heavily on the PST for approval. In the same way, the PST could conduct a review, and rescind a DNR order. At least 20% of the individuals at ABSSLC had no guardian. In response to this issue, the Medical Director authored and implemented a procedure to rescind a DNR when applicable. The procedure was entitled, "Procedures for Rescinding A 'Do Not Resuscitate Order' (DNR)," dated June 25, 2010. The procedure required a PST meeting in which the guardian/health care agent/relative participated in the decision. It began with the physician and the team reviewing the record to determine if a person still had a "terminal or irreversible condition," which were considered qualifying conditions. From this policy, the Medical Director was aware of two individuals from his caseload for whom the DNR was rescinded, including: ▪ The record of Individual #213 was reviewed. A physician note documenting the discussion of rescinding the DNR order at the team meeting was followed by a 6/1/10 entry in which a conversation with the individual's correspondent was recorded, and an order to discontinue the DNR was entered on 6/1/10. ▪ The record of Individual #232 was reviewed. A note on 6/3/10 documented the conversation with the individual's correspondent, followed by a discontinuation of the DNR order. According to the Medical Director, all primary care practitioners were requested to re-examine the DNR order of each individual at the time of the Semi-annual Case Conference (SCC). The PST was tasked with reviewing and revising the justification for the DNR, or rescinding the order for DNR if it no longer was justified. However, the review and order did not have to wait until the SCC, although that was the timeline provided. For instance, Individual #100, a resident in the Infirmary at the time of the review, had an order for a DNR, and the attending physician was not aware of the DNR status until the Monitoring Team requested to review the order. He then began the process of reviewing and/or rescinding the DNR. For those individuals that are acutely ill, and have an order for a DNR, but are not terminal, it is recommended that the review be prioritized.	

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		In reviewing the procedure for rescinding a DNR order, there were two qualifying conditions stated. The terminal condition was one that was appropriate for all populations, specifically that death was expected within six months even with life sustaining treatment. For individuals in this category, when one survived extended periods of time beyond the six months, then one would reconsider if the DNR was still appropriate. If hospice were to be involved, they have guidelines in place to assist in determining if a person remained qualified. The other qualifying condition was more complex, and could lead to an aggressive approach to DNR, which would not necessarily benefit the population with ID/DD. The second qualifying condition was listed as an irreversible condition, with examples of life sustaining interventions. It was far clearer to focus only on the first qualifying condition, as this second qualifying condition introduced levels of subjectivity and potential bias, which at times could have created decisions not in the best interest of the individual, nor in the best interest of those caring for the individual. Although this was possibly appropriate for an elderly individual with Alzheimer's disease undergoing severe end stage decline, it was less readily translated to the ID/DD population. Many individuals in the ID/DD population were born with genetic and congenital health issues that could be labeled as irreversible conditions, yet are stable with minimal or slow decline. However, if misapplied, the implication of this second condition was that these individuals should have had DNR orders from birth. Some individuals have had feeding tubes and enteral nutrition since childhood, and have had many years of a meaningful life, but by this definition, they would be qualified for a DNR order, and so the decision would be made to forgo necessary nutrition and hydration during an acute illness, often a treatable illness. It was noted that the "Texas Department of Health Standard Out-of-Hospital Do-Not-Resuscitate Order" form did not list artificial hydration and nutrition or dialysis as options to be considered to be withheld, which led to confusion in gaining guidance from the definition of "Irreversible Condition." The Facility policy included these as life-sustaining treatment. Considerably more guidance, and a review of historical legal precedents in Texas and nationally should be considered in determining the appropriate application for the PSTs and physicians in using this second qualifying condition. The Medical Director reported consulting with the Records Coordinator and State's attorney concerning the rescinding of the DNR, but there was no specific guidance as to the use or interpretation of the second qualifying condition in the context of the ID/DD population residing at ABSSLC. It may be important to further consult the state's legal department to review how this second qualifying condition is implemented. Because of the complexity of the issues, most states have been extremely conservative with allowing a DNR for those with irreversible conditions, but have guidelines/criteria for a DNR order when there is a well-defined terminal illness that would lead to death within six months. For many	

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		individuals with developmental disabilities, their baseline function included such life-sustaining treatments such as feeding tubes, or dialysis, and to consider these treatments as reasons not to provide DNR may risk unnecessarily shortening their life spans, and from other points of view be considered devaluing of the individuals and their rights. ABSSLC staff should be advocates for the individuals to support and encourage whatever potential level of independence, health, and safety is possible. ABSSLC staff, especially the health care professionals, should be advocates when individuals are hospitalized, to use all resources available to anyone else, and not be limited in thinking or expectations because of what others may perceive as poor quality of life. To those with ID/DD who were born with functional limitations, from their perception that is their normal status, and any treatment provided should have a goal of returning them to this baseline function. Whatever function they have been able to develop and attain should be aggressively preserved if at all possible, not used as a reason to provide less care. A DNR, when not appropriate, fails to protect the independence, health, and safety of the individual. Because these issues may be contentious, emotional, and extremely complex, with legal precedent in the state and nationally, it is suggested that a training curriculum be developed for members of the SSLC's Ethics Committee to ensure they are well versed in this aspect of medical/legal concerns. There needs to be a clear policy and procedure that describes the steps to be taken in instituting a DNR for an individual at ABSSLC. Once a PST along with the guardian/family makes a decision for a DNR order, the interface between the Ethics Committee and the PST should be clarified and any meetings should be timely. Alternatively, a member of the Ethics Committee may be assigned to each case and be represented at the PST of the individual. At the State level, there should be review at all SSLCs to standardize the approach to this issue in manner consistent with state and federal laws and regulations. Considering the difficult and sensitive issue of DNR with this population, an outside opinion would verify that the DNR status of any individual is appropriate at the time of the order. In other states, this may require the agreement of opinion by two off-campus physicians who have not participated in care of the individual. It may be easiest, however, to have the individual assessed by Hospice services to determine eligibility for terminal hospice care (versus palliative care). Hospice also would routinely provide a periodic update, and if the individual becomes well and no longer qualified, they would assess this and inform the PCP. The following are examples of individuals for whom DNR orders were present, but for whom teams should reconsider the orders based on their current status: ▪ Individual #431 had a DNR order, dated 12/18/01, for the following qualifying	

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		conditions: "penetration on pureed meat, honey thick liquids and disordered peristalsis on modified barium swallow. Inadequate oral intake caused dehydration and weight loss required G-tube feeding to sustain life. Unable to care for self and depends totally on staff for her care." Since that time, her dysphagia had been a treatable diagnosis, and she had lived many years. Many individuals are unable to provide self-care at various levels, but this does not automatically make them candidates for DNR status, nor are they labeled as terminally ill. It is recommended that the Medical Department and PST reevaluate her DNR order to determine it is appropriate. ▪ Individual #10 had a DNR order, dated 11/13/01, for the following qualifying conditions: "recent severe episode of status epilepticus treated aggressively at [the] Medical Center. This problem presents a very real risk of a recurrence and a possible fatal outcome at any time. Severe osteoporosis with history of multiple fractures including a non-union fracture of the left distal femur which ultimately required an above the knee amputation. Cardiopulmonary Resuscitation (CPR) would be associated with a high risk of fracture of ribs and other bony trauma." The actual order at the time was in the context of a pneumonia in which the PCP was concerned about respiratory failure. The PCP called the next-of-kin for an out-of-hospital DNR, and she agreed, but wanted to treat the pneumonia at ABSSLC, and not transfer him to the general hospital. From the PCP note, it was not clear that once he recovered from the pneumonia that the decision would continue to apply, but he continued to be identified as having a DNR order in effect. He also had been to the hospital since that time (as recent as 6/18/10 for left lower lobe pneumonitis, and 7/31/09 for pneumonia). ▪ Individual #100 had a DNR order as of 4/16/09, due to "his severe seizures causing permanent and irreversible brain damage" as "he had shown significant deterioration in his overall mental status." However, a neurology consultation on 10/12/09 documented good seizure control. During this time, he had been placed on Lyrica, and the medication Dilantin, which had caused toxic side effects, had been discontinued. It is recommended that the PST revisit this decision and consider rescinding the DNR, because his health status concerning seizure control has changed. ▪ Individual #208 had had a DNR since 6/27/03. According to the Annual Medical Summary/Physical Examination, dated 1/25/10, the qualifying conditions were: "renal cell carcinoma with right radical nephrectomy done in 2001. Recurrence of renal cell carcinoma can reoccur at any time after nephrectomy. Profound anorexia with absolute refusal to take any oral intake in past 6 or more weeks. An attempt to place a surgical J-tube will be made…on 10/30/07. The risks as far as morbidity and mortality are very high and the risk of perioperative death are well above average because of his age and overall poor state of heath. Without a permanent feeding tube, however, death in the near future is almost a	

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		certainty. In view of his serious health problems, I consider that he currently has a terminal and irreversible condition…" The conditions for his qualifying conditions appeared to have changed, yet his DNR status had remained. A J-tube was successfully placed, and the risk of perioperative death mentioned as part of the qualifying condition had not been applicable since his surgery in 2007. His renal cell carcinoma had not recurred. It is recommended that the PST revise the qualifying conditions or rescind the DNR. ▪ Individual #361 had a DNR order placed on 7/5/01 for: "the determination of irreversible condition: cerebral dysgenesis due to encephalomyelitis secondary to intrauterine herpes virus infection. Secondary problems: severe oral and pharyngeal dysphagia with aspiration. This may be treated but never cured." It is recommended that the PST review the applicability of this DNR, nine years after it was ordered. It was not clear the reason why her cerebral dysgenesis, which she had had all her life, would be a cause for DNR status in 2001. ▪ Individual #317 had an order for DNR placed on 2/17/05. Qualifying conditions listed included: "brain damage due to intrauterine ischemia and prematurity, severe spastic quadriparesis, severe scoliosis with flexion contractures of all extremities, dysphagia with aspiration of liquid and solid food …requiring G-tube feedings to maintain her nutrition, and recurrent bronchospasm with respiratory distress." At the time of the review, she was considered medically stable. None of the conditions listed would be considered reasons not to provide aggressive treatment, and the PCP and PST should consider revising the qualifying conditions or rescinding the DNR. That she was considered medically stable suggested that heroic measures should be offered should that be necessary to sustain life. ▪ Likewise, the following individual with a DNR due to qualifying conditions needs to be reviewed to determine if a DNR is still acceptable, or to change the documentation of irreversible/qualifying condition so that there is a compelling medical reason not to offer CPR should it be needed. Individual #492 had a DNR placed on 8/25/04 for "severe brain damage, bulbar paresis, cerebral palsy with spastic quadriplegia, dysphagia, recurrent aspiration pneumonia. He has a gastrostomy tube. Without this life-sustaining treatment, he would die." The following provides an example of an individual for whom an appropriate and logical process was used in making a decision about placement of a DNR order: ▪ Individual #531 developed a pneumonia on 2/11/09, had chronic hypoxia on 1/17/10, and fever on 1/18/10 associated with emesis and continued hypoxia associated with a viral upper respiratory infection. A documented conversation between the PCP and family discussed the recommendation of DNR due to her severe rotoscoliosis causing restrictive lung disease and osteoporosis in which case chest compression would cause multiple painful rib fractures. An Ethics	

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		Committee meeting on 2/3/10 agreed with the DNR order. On 2/23/10, she developed hypoxia and fever, and was diagnosed with pneumonia. Her baseline oxygen saturation was 88 percent. On 3/20/10, she developed fever and hypoxia and was diagnosed with pneumonia and cystitis. On 6/6/10, she was noted to have an increased respiratory rate and fever, and she was transferred to the Infirmary and diagnosed with pneumonia. She did not respond to intravenous (IV) antibiotics, and required more oxygen supplementation (partial rebreather at 92 percent). Because of her lack of response, the PST met on 6/10/10, and agreed to consult Hospice for comfort care. The mother was contacted and agreed. She died under Hospice care within a few days. This case represents a well thought out and well documented process of someone with a terminal illness of end stage respiratory failure from severe restrictive lung disease complicated by repeated pneumonias. The PCP, Ethics Committee, PST, and parent were part of the decision-making process. In her case, despite all that was being done, she was on a downhill clinical course. It appeared that she was offered all routes of treatment in her last year of life, and no other options were available. In this case, the DNR seemed appropriate. It was also important that Hospice was involved, to be an outside provider validating agreement with the DNR, and providing consultation in comfort care. It is recommended that the Medical Director review this case, and use it as an example of a tested and successful blueprint to create a policy outlining the process of obtaining a DNR. <u>Mortality Reviews</u> Mortality reviews are an excellent way to review quality of care and risk management. The most recent mortality reviews were requested from the Medical Department. A list also was provided of "Death Reports Still to be Completed." This report included dates of death from 7/17/10 back to 10/11/09. No death reports had been completed for deaths occurring from mid-October 2009 to the present. The death reports remaining incomplete at the time of the visit totaled 17 cases dating from 10/11/09 to 7/17/10. This is problematic, in that urgent issues identified through trend analysis and review of cases will not be discovered for many months, up to a year. Additionally, much information is lost through time as the details of the events leading up to death, or the details of the individual's life, are best recalled in proximity to the death, not nine months to a year later. The most recently completed death reports were reviewed. Two forms were routinely completed. The Medical Department completed the "Abilene State Supported Living Center Death/Discharge Summary." The Nursing Department completed the "Quality Improvement Death Review of Nursing Services." In addition to significant concerns regarding the timeliness of the mortality reviews, the	

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		following provides examples of concerns related to the quality and thoroughness of the reviews: ▪ The clinical death review committee met on 12/2/09 to review the death of Individual #445 (DOD 7/22/09). This individual was found deceased seated in his wheelchair. The initial impression as a cause of death was aspiration due to emesis of formula from gastroparesis. An autopsy was completed, and the death certificate was amended to identify the causes of death as sudden death, hypertensive heart disease, and atherosclerotic heart disease with significant contributing factor of aspiration of gastric debris. The autopsy revealed the lungs were congested, and aspirated gastric debris was found in several areas with no notable inflammatory reaction visible. He had a G-tube in place, which was reported to be leaking at least twice on 5/28/09, and 6/12/09. This individual had pneumonia on 4/20/09. On 6/10/09 he was noted to be hypoxic, wheezing, with a productive cough. On 6/16/09, he was determined to have a right-sided pneumonia. His lungs cleared briefly, and then on 6/22/09, he developed coarse breath sounds, which continued through 7/12/09. He completed three courses of different antibiotics during this time. Then, on 7/22/09, he was found unresponsive. CPR was not successful. Although there are several possible causes for his persistent coarse breath sounds, wheezing, hypoxia, and pneumonia over the weeks to months prior to his death, severe GERD may have been a significant concern/contributor with this history, with subsequent chronic aspiration as the etiology of the wheezing, hypoxia and difficult to cure pneumonia. With a history of gastroparesis, aspiration from GERD is even more of a heightened concern. However, there was little information to suggest a work-up for GERD, or further interventions such as J-tube placement, or Nissen fundoplication, or review of the fundoplication if one was in place to determine if it had become unwrapped and needed correcting. However, the death review concluded: "Following the review, the committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." ▪ The clinical death review committee also met concerning Individual #28. The date of death was 10/4/09, and the meeting was held 7/6/10. She had a primary liver cancer, and an acute care plan to address her pain was initiated on 8/20/09. Hospice care started on 9/2/09. There were several care plans that appeared to meet her health needs. The RN case manager reviewed the plans periodically for any needed revisions. Despite her downhill course, on 6/2/09 the health status team met and determined she was at low risk in all areas except aspiration and choking. She was considered medium risk for aspiration and choking. The team then met on 9/3/09, a day after she started with Hospice, and reassigned all areas to low risk, despite her being considered terminal. The PCP changed her risk rating to high on 9/16/09, and she expired	

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		within three weeks. By identifying someone who was terminal and dying as low risk for health care issues, the team clearly did not understand the risk monitoring system. This would have been an excellent teaching opportunity across the campus. It would have been an opportunity to revisit the purpose of the risk monitoring, and learn from this case where the gaps were with regard to training and education. However, the committee report indicated: "following the review, the committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." ▪ A clinical death review committee met on Individual #161. He died on 7/25/09, and the committee met on 1/13/10. A Percutaneous Endoscopic Gastrostomy (PEG) tube was placed 1/30/07, due to an abnormal modified barium swallow evaluation. Of note, a repeat modified barium swallow was completed on 3/21/07, and the results were considered to be normal. On 7/17/09, there was an order for a protein supplement to be given by mouth, as he had developed pressure induced skin breakdown over his sacrum. The PCP became aware of the order on 7/20/09, and stopped all orders for PO feedings and medication; his G-tube was to be used for all intake. However, the nurse did not discontinue the PO order on the MAR on 7/20/09. As most staff were aware he was to have nothing by mouth (NPO), it is not certain if any staff, particularly any new or covering staff, may have provided him the PO supplement. Then, there were references to the same event occurring on 7/22 and 7/23/09 at 3:15 a.m., so it is unclear on which date it occurred. Specifically, the home support staff noted he vomited a large amount, and the Licensed Vocational Nurse (LVN) was informed at that time, but there was no nursing documentation present indicating any assessment or treatment. He then was found at 8:30 a.m. in bed with a large amount of emesis, cyanotic, and in need of suctioning. The RN case manager called for oxygen, suctioned him, and placed his G-tube to drainage to empty the stomach contents to prevent further vomiting. On 7/23/09, he was admitted to the Infirmary at 9:58 a.m. for suspected pneumonia and hypoxia. He was provided IV antibiotic, oxygen, and nebulizer treatments of Albuterol and Mucomyst. However, he did not respond, remained hypoxic, and was transferred to the hospital at 10:35 a.m. He died in the hospital on 7/25/09. The death certificate indicated cause of death as shock due to aspiration pneumonia. The nursing death review included several important recommendations. These included both in-service trainings and changes in protocol/policy. RNs and LVNs were in-serviced regarding assessment, treatments, and follow-up documentation when home staff report an illness or injury of an individual. Another in-service was provided to nurses regarding noting orders and clarification of orders, with focus on writing PO orders for an individual receiving all medication and feedings by a g-tube. Additionally, the frequency of checks on an individual was increased from every 30 minutes to	

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		every 15 minutes. Another recommendation was that the PST meet for all those individuals confined to their bedrooms to determine if an increase in level of supervision was needed. There were several areas which could have led to systemic changes in improvement in care at ABSSLC, but the final recommendation from the committee was "following the review, the committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." ▪ The Clinical Mortality Review Committee also met on Individual #249. He had a G-tube placed in 2003 for aspiration pneumonia, and subsequently, at least dating from 9/08, had pneumonias and aspiration pneumonias, as well as Chronic Obstructive Pulmonary Disease (COPD) and bronchitis. He died of respiratory failure. His death certificate indicated the cause was due to aspiration pneumonia. Although the acute care was appropriate, there was no long-range view of the pathophysiology occurring in this individual. For those who require a G-tube to prevent aspiration, who subsequently over time, once again develop respiratory problems with aspiration pneumonias, an important next step would be to consider a work up for GERD, and aggressive management. However, the committee report indicated: "Following the review, the Committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." ▪ The Clinical Mortality Review Committee also met on Individual #173. This individual had a history of reactive airways disease. He had a Purified Protein Derivative (PPD) conversion, and an infectious disease consultation was completed. Isoniazid was started, but caused leukopenia and thrombocytopenia, and was stopped on 7/28/09. His medication was changed to Rifampin and Pyrazinamide. He was admitted to the Infirmary from 8/1 to 8/6/09 for pneumonia, and again admitted to the Infirmary on 9/4/09 for pneumonia. The following day, he developed unstable vital signs and neurological deterioration. He was transported to the hospital where he was found to have a right-sided hemorrhagic stroke. The family at that point requested a DNR, and he was admitted to hospice. He returned to the Infirmary on 9/14/09, under hospice care, and passed. The final statement of the committee was: "Following the review, the Committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." This case was an unexpected tragic event, which could not have been prevented, according to the documents reviewed, and the Committee statement accurately reflected that no further recommendations could be made. ▪ The Clinical Mortality Review Committee also met concerning Individual #372. He had a history of seizure disorder, having had seven seizures in 2009. The last seizure prior to his death was recorded as seven days prior to death, and lasted 45 seconds. The last neurology consultation was a year prior on 9/15/08, and he	

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		was considered satisfactorily controlled. He had excellent health in 2009. Blood work during 2009 was unremarkable. On 9/13/09, he was noted to have a loose nonproductive cough. On 9/15/09, he was found to be jerking in his wheelchair. On 9/16/09, he was observed to be coughing, but his lungs were clear on auscultation. On 9/17/09, his vital signs were recorded and were normal, including oxygen saturation. On 9/22/09, he developed a fever of 101, and a cough. The PCP examined him and the exam was not remarkable. He was described as alert and cheerful, and was asking for a hamburger. His fever came down to 99 within two hours. In the evening, after eating all his supper, he spent time in the living room listening to his radio. Later, when he was found sleeping in his wheelchair, he was taken to his bedroom. Once in the bedroom, the staff realized they needed to obtain some bed pads, and went to get these. On return, the staff noticed he "did not look right," and called the home LVNs. The staff removed the individual from the wheelchair to the floor to begin CPR. The operator was called at 4444 at 7:27 p.m., and the operator called 911. The Treatment Room nurse arrived at 7:35 p.m., and assessed the individual. Finding no pulse or respirations, an Automatic External Defibrillator (AED) was placed on the individual, and CPR was recorded as starting 7:35 p.m. according to one document. Because of ongoing emesis, respiratory assistance was difficult. Emergency Management Services (EMS) arrived, he was intubated, and taken to the local medical center. He was pronounced dead at 9:08 p.m. As noted in this description, the staff noticed he "did not look right," and called the home LVNs. The amount of time lapse is not known in those critical minutes. Also, the arrival of the LVNs was not ever recorded, and may not have occurred according to the document. However, upon discussing this issue with the Medical Director, it was shared that the LVNs did arrive and start CPR before the Treatment Room nurse arrived. The documents suggested CPR did not start until 7:35 p.m., which was eight minutes after discovering he was lifeless. It is recommended, that in the future, precise recording of times of codes be recorded, as well as those licensed staff in attendance, to ensure that codes are conducted in a timely manner. This death also brings up the training of the direct care staff. If the only comment recorded was that he "did not look right," this suggests the need for further training of health status changes. The direct support professionals should be able to articulate at the time, and later during documentation and interviews, a helpful description of the appearance of the individual. Direct support professionals need to learn to observe for certain signs and symptoms, and be able to articulate these clearly to the covering licensed health care staff. Considering his death was ultimately considered to be associated with seizure	

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		activity, it would have been helpful to know if there were any signs of having had seizure activity, and to have such information communicated to the staff at the scene conducting the code. The death certificate stated the cause of death was acute aspiration due to presumed seizure activity, based on autopsy findings. There was documentation of emesis during the code, which impeded the code, but there was no information as to whether the staff noted any findings suggesting emesis at the time he "did not look right." Further accurate documentation of details may have been helpful in determining the series of events. From the information available, it did not look like suctioning the individual prior to the code was indicated, as no emesis was noted, nor coughing with gagging. Whether a suction device was available at the time of the CPR was not recorded, and whether it was used, was not recorded in the documents reviewed. The Committee minutes recorded: "Following the review, the Committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." ▪ The Clinical Mortality Review Committee also reviewed Individual #419. This individual had a significant history of reactive airways disease, repeated pneumonias, and constipation with fecal impaction. In January 2009, he was admitted to the hospital for constipation and fecal impaction, as well as pneumonia and reactive airways disease. In February 2009, he had pneumonia. In June 2009, he had reactive airways disease. In August 2009, he had an upper respiratory tract infection (URI). On 9/19/09, he was culture positive for influenza A and treated with Oseltamivir. On 9/21/09, his lung sounds were coarse, and his oxygen saturation was 92 percent on room air and his respirations were 20 per minute, with a pulse of 110. On 9/23/09, his chest x-ray was interpreted as left lower lobe pneumonia. On 9/24/09, he was admitted to the Infirmary. With a high temperature of 104.7° Fahrenheit (F), pulse 120, and oxygen saturation of 96 percent on two liters (L) of oxygen (O2). A chest x-ray on 9/24/09 was read as unchanged from the x-ray the previous day. Abdominal x-rays were done on 9/24/09 and 9/26/09, and both showed a large amount of colonic gas and fecal material, and there was no significant change reported in the films. On 9/28/09, his pulse had risen to 140, his respirations were 32, and his oxygenation was 77 percent. The oxygen rate was increased to 3.5 liters per minute and his oxygen saturation at that time was 95 percent. A tracheal aspirate was positive for Methicillin-resistant Staphylococcus aureus (MRSA), and he was subsequently started on Vancomycin. On 9/29/09, it was recorded his abdomen was distended. Then on 9/30/09, he went into respiratory distress, 911 was called, he was transported to the hospital, coded in the Emergency Room (ER), and resuscitated in the ER. A subsequent EEG was done and indicated no brain activity. At that point, all life support was withdrawn.	

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		Concerns were noted with regard to the timeliness of transfer of critically ill individuals to the hospital. In this case, both on 9/24/09 and 9/28/09, he showed evidence of deterioration. It was not clear what the threshold indicators were for transfer to the hospital. Had he been transferred sooner, he perhaps would not have coded in the ER, but would have benefited from inpatient hospital care prior to that. Whether the end result would have changed cannot be determined; however, he was transferred at the last hours of his life when he had been ill for several days. It is recommended that the Medical Department develop criteria with regard to transferring an individual to the hospital for use by all primary care practitioners. This would allow an objective basis for making such decisions, and ensure standardization of aggressive treatment. The Clinical Mortality Review Committee Report concluded: "Following the review, the Committee concluded that the medical care rendered to this individual was appropriate and thorough. No recommendations were made." Mortality reviews can have two components. The first component is the clinical death review that provides an opportunity to review in detail the time period leading to the downhill course and death of the individual, and gain longitudinal information so as to apply it to current practice. Mortality review information can have a positive impact on clinical care. Additionally, as a second component, there is the unique opportunity for each department, not just the medical and nursing departments, to review documents spanning the life of the individual, including decisions that were made and their outcomes over many decades. Mortality reviews have the ability to be highly educational with many recommendations, often with one or more of such recommendations for each department on campus. Yet, the ABSSLC Clinical Mortality Review Committee repeatedly had no recommendations. There may be some concern that there is increased liability or discoverability when reviewing such cases. If so, it is unfortunate that this has had such a negative impact on mortality review system at ABSSLC. Individuals' lives would be improved if the process allowed for critical review, and lessons learned could be applied to others. Due to the limited confidentiality of peer review documents, the State should identify methodologies to ensure that thorough death/mortality reviews are completed. Until that happens, there is much that will not be learned, and opportunities for applying these lessons to the lives of other individuals will be lost. The Monitoring Team also conducted a review of selected deaths for those individuals for whom a death review had not been completed yet. The following examples describe some of the concerns noted: ▪ Individual #340 had complications following surgery, in which a small bowel infarction was resected, a J-tube was placed, but post-operatively the clinical course was complicated further by wound dehiscence. This subsequently was	

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		repaired. He continued to do poorly, but after further testing, there were no other surgical or medical treatments that could be offered that would be in his best interest and that would sustain him, and he was placed on Hospice. He had a DNR order dating back to 7/16/04. However, after he was placed on Hospice, it was recorded on 1/28/09 that the family was upset that he was not being fed or hydrated under Hospice care. This suggested that they were either not part of the decision process (which may be difficult if there are several different family members), or did not understand the implications of the discussions and decisions. This was subsequently resolved, but it is recommended that there be a review of end-of-life care at ABSSLC. This should include clear communication with family/guardian/power-of-attorney. The family should be part of the team meetings in which discussions occur about providing comfort and palliative care. Additionally, there were some potential irregularities with the choice and administration of medications. This individual had a history of gastrointestinal bleeding as recently as 10/22/08, but was on aspirin, and late in the clinical course had a positive guaiac stool. He was on medications to treat the erosive esophagitis, including Protonix, Reglan, and Carafate. However, it was noted the Carafate was administered through the J-tube, which would provide little benefit to the lining of the esophagus or stomach. These issues pre-dated the clinical pharmacist, and with the clinical pharmacist recruited, these concerns should be addressed in the future. This individual was complex and required many medications, and an additional review by the clinical pharmacist should question and resolve such issues as they occur. ▪ Individual #62 had a long history of hydrocephalus, with a slow downhill clinical course. Serial Computed Tomography (CT) scans of the head from 5/17/04 to 2/19/10 indicated no significant change in ventricular size and position of the bilateral ventriculoperitoneal shunts. On 6/19/10, this individual fell off the bathing table and hit her head, sustaining a subdural hematoma. Due to her prior chronic downhill course, aggressive treatment was not offered. She was provided care consistent with a DNR, although the rationale for not attempting to remove the subdural hematoma was not clear from the review. Her subdural hematoma was an acute event, and in this case, a life-threatening problem related to trauma, rather than an untreatable terminal condition for which no treatment was possible. Surgery may have been life-saving and returned her to her prior functional level. ▪ Individual #134 had a history of seizures and chronic constipation. On 6/15/10, she developed hypothermia with a temperature of 95.8° F, and a warming blanket was applied. Again on 6/19/10, she developed hypothermia and blankets were applied. On 6/20/10, she was reported to have refused meals and liquids, but had a normal temp as of 11 p.m. On the morning of 6/21/10, she	

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		was noted to be her usual self at 5 a.m., but was found unresponsive at 5:30 a.m. CPR was begun. An autopsy was completed and the cause was determined to be sudden death associated with seizure disorder. From review of the record, her body temperature had restored itself to normal, and she was acting her usual self. This was an unexpected death with no indications of unstable health signs or symptoms shortly before her death. It would appear that all appropriate measures were taken. ▪ Individual #331 had developed pneumonia, sepsis, and acute renal failure on 5/11/10, and recovered. She then developed a Urinary Tract Infection (UTI) on 7/8/10, and was prescribed an antibiotic. She spiked a fever, and was transported to the ER on 7/9/10, and returned with a diagnosis of urosepsis, an indwelling Foley catheter, and recommendations for IV antibiotic. On 7/12/10, she developed respiratory distress, and was sent to the ER. She was found to have pneumonia and a low platelet count. There was discussion about returning her to ABSSLC, but she remained at the hospital. She developed congestive heart failure, adult respiratory distress syndrome and bilateral pneumonia. The nurses and PCP had been informed that the ER was organizing her return on 7/12/10, and were advocates in ensuring she was admitted for appropriate treatment rather than returning to ABSSLC. ▪ Individual #90 had a DNR placed on 4/16/01 for: "cerebral palsy with spastic quadriplegia, a permanent condition; unable to care for own self, and requires total care by other people/staff; unable to eat by mouth due to choking and aspiration of food; required G-tube for feeding to sustain life." These conditions, which were life-long, were determined to be reasons for not pursuing aggressive measures. This individual had a PEG tube placed 5/10/01 for choking on food, and refusal to eat and drink with weight loss. On 4/18/09, she developed respiratory distress after vomiting. She was admitted to the Infirmary and treated for pneumonia. On 9/13/09, she vomited followed by worsening breath sounds (rhonchi) and rapid heart rate. She had possible aspiration pneumonia and was admitted to the Infirmary. On 12/13/09, this individual vomited followed by coarse breath sounds. On 12/20/09, she vomited formula colored emesis. On 12/23/09, she vomited followed by oxygen desaturation. She was transferred to the hospital and returned on 12/26/09, with a diagnosis of pneumonia, as well as constipation with impaction. Her x-ray was read as a right middle lobe infiltrate. On 2/25/10, she developed fever and hypoxia, and was found on chest x-ray to have a right lower lobe and right middle lobe pneumonia. A CT scan of her chest revealed pulmonary fibrosis. On 3/20/10, she vomited a large amount of formula colored emesis, and then vomited twice more followed by coarse breath sounds. She required admission to the hospital. She returned on 4/1/10, but then vomited again. At that point, there was a recommendation from the hospital that she be admitted to Hospice care due to	

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		the continued serious aspirations. She clinically deteriorated on 4/2/10, and was sent to the hospital. She returned after an ER visit, and was placed on Hospice for recurrent aspiration pneumonias. Unfortunately, there was little information in the record regarding whether there was consideration of an Esophagogastroduodenoscopy (EGD) to rule out gastritis (last one was in 2001), or esophagitis; whether there was a consideration of a Nissen fundoplication and J-tube placement to prevent further aspiration of formula through GERD or vomiting; or whether there were contraindications to the latter procedures. Additionally, there was little information as to her positioning before the vomiting. Also, the relationship of the fecal impaction to the vomiting and aspiration was not clear, but there were two events in which they occurred together. Little information was recorded as to the next step in the many potential causes and contributing factors of her vomiting and aspiration. Generally, the record should reflect that all possibilities have been pursued and ruled out, leaving someone in an inevitable decline for which hospice can offer excellent palliative care. It is recommended that for all those with repeated aspirations, a series of diagnostic tests and procedures be considered and documented as being appropriate or not being appropriate for that individual in order to ensure all individuals at ABSSLC are provided the same level of aggressive medical treatment. This would be best accomplished through a clinical pathway with expectations that all staff adhere to the guideline. <u>Acute and Preventative Care</u> Once an acute care problem was identified, there seemed to be timely and up-to-date medical management. However, critical clinical thinking also needed to be directed toward the reason the clinical event or deterioration was occurring. For example: ▪ Individual #59 sustained a fracture of her left wrist. Risk factors were present, such as post-menopausal state, with a seizure disorder and psychiatric disorder requiring medication that is associated with osteoporosis. On review of the record, a Dual energy x-ray absorptiometry (DEXA) scan had been ordered at the time of the annual medical summary and physical examination evaluation on 2/8/10. However, there was no evidence in the record this had been completed. Although submitted radiographic studies dated back into 2009, no DEXA report was found. Also, this individual was not on calcium supplement, which is a standard preventive measure in a post-menopausal female unless contraindicated. She was on supplemental Vitamin D. It is problematic that the DEXA report was either not completed or not available for review. If the DEXA was not completed, this represents a system problem in which ordered tests are not tracked until completion. If completed, the results did not seem to have been available for review by the PCP. There did not seem to be the critical	

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		questioning as to the reasons for a fracture in a post-menopausal female on medication associated with risk of osteoporosis. ▪ Individual #100 had several pneumonias in the past recent months. On 1/17/09, he was diagnosed with right lower lobe pneumonia. He deteriorated the next day, and was hospitalized, and placed on a ventilator. He developed MRSA pneumonia. He also during that time developed a second pneumonia. He had a prolonged course and was returned to the Infirmary on 2/16/09, with return to his home on 3/10/09. He also was diagnosed at that time with "hypoxic episodes secondary to bronchitis." On 3/14/09, he again had hypoxia and cyanosis and was diagnosed with left lower lobe pneumonia, again requiring hospitalization. He was diagnosed on 5/17/09 with right lower lobe pneumonia. On 7/7/09, he developed respiratory distress, and was hospitalized for aspiration pneumonia. During this admission, a PEG tube was placed. He was placed on bolus feedings. On 7/19/10, he was found to have a productive cough. Sputum was described as "thick formula colored," suggesting severe reflux of formula. He then vomited, and developed cyanosis. On 7/21/10, he vomited twice more, and developed a fever, at which time he was admitted to the Infirmary. He then vomited again and developed hypoxia, requiring hospitalization. He again developed acute aspiration pneumonia. On review of the submitted documents, there was no indication that there was consideration of further work-up of repeated aspiration pneumonias or pneumonias to determine the reason for the occurrence in this individual. That he was coughing up formula colored sputum two days before development of respiratory distress and pneumonia suggested the need to rule out severe GERD as a contributing cause of recurrent pneumonias. When formula was observed in sputum, or if it were observed in the mouth of this tube fed individual, evaluation for GERD should be rapidly completed, as well as changing the formula rate, which had been bolus, to a slow intermittent or continuous flow. Meticulous attention to positioning so that the individual would not ever lie flat would also be recommended. If GERD was discovered, then options would include a Nissen fundoplication and a J-tube placement, if changing formula flow rate and positioning monitoring were in place and did not resolve this issue. However, at the time of the review, there did not seem to be the clinical testing and consultation that would benefit the individual in preventing further episodes of pneumonia. ▪ Individual #511 had a history of recurrent pneumonias (1/85, 2/89, 11/89, 2/92, 6/09). His last Modified Barium Swallow was 9/16/09, and his last orders were to thicken all liquids to a thick pudding consistency. On 12/31/09, he was noted to have a week of progressive anorexia associated with fever. He had no significant cough or respiratory distress. Chest x-ray showed a left lower lobe	

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		infiltrate. He returned to his home on 1/5/10. On 5/17/10, he had chest congestion, low-grade fever, and hypoxia that required supplemental oxygen, and a diagnosis was made of pneumonia. A chest x-ray was interpreted as right lower lobe infiltrate. On 7/18/10, he developed tachypnea and hypoxia. He was transferred to the hospital. His chest x-ray revealed bilateral consolidations and right upper lobe cysts or cavities. He returned to the Infirmary on 7/29/10, and was discharged to his home on 8/4/10. He was on a pureed diet, and at times ate well and at times refused. Megace did not improve his appetite. Periactin did seem to be associated with weight gain in the past and was resumed. It was not clear why he had not been reviewed for silent aspiration with a modified barium swallow study, because it had been almost a year since the last one, and he continued to have recurrent pneumonias. Also, monitoring of his positioning would have been important, as GERD would be made considerably worse by lying flat. He also had a history of peptic ulcer disease, in which case an upper gastrointestinal endoscopy might be indicated. If he were determined to have dysphagia or GERD with aspiration, various surgical procedures would be indicated. A G-tube would be indicated for dysphagia, but a Nissen fundoplication and J-tube would be indicated for GERD. A feeding tube would also be indicated if his weight continued to fall and he remained anorexic. However, there was not the critical next step offered to the individual at the initial review. ▪ Individual #208 had a complicated history of bleeding gastric ulcer, requiring a vagotomy, hiatal hernia repair, a hemigastrectomy and gastrojejunostomy, as well as suturing of a bleeding duodenal ulcer. Later he had a J-tube placed. Since that time he had had frequent vomiting associated with pneumonia (5/1/09, 5/18/09, 8/3/09, 9/12/09, 9/24/09, 10/3/09, 12/4/09, 6/18/10, and 6/28/10). He was referred for an EGD on 5/8/09, and was diagnosed with esophagitis. More recently, he continued with vomiting on 7/8/10, 7/9/10, 7/10/10, 7/12/10, 7/17/10, 7/18/10, 7/22/10, 7/23/10, 7/24/10, 7/29/10, 7/30/10, 7/31/10, 8/1/10, 8/2/10, and 8/3/10. On 7/10/10, upon removal of his J-tube dressing, "a strong fecal smell was noted as well as the dressings being soaked with brown, feces colored drainage." There was a gastroenterology consultation 11/10/09, referred because of the vomiting to that point in time. The only recommendations at that time were for a trial of Erythromycin or Amitiza. The physician orders provided for review since that time did not seem to include orders for either of these medications. Since then, despite the intractable vomiting, there has been little pursuit of the cause. There are many potential causes of vomiting in this individual, including abdominal adhesions, pancreatitis, recurrent gastritis/esophagitis, medications which may be aggravating intestinal motility, remote effects of an occult recurrent cancer, vestibular disease, etc. Referrals to a surgeon, and a second opinion from a	

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		gastroenterologist are recommended as options. Additionally, with the vomiting, it is not certain as to the degree the medications are being absorbed, and whether the aspirin is aggravating his condition. A CT of his abdomen may be helpful, if not completed recently. The clinical pharmacist may need to review medications given through the J-tube to determine if any were potentially harmful and a source of vomiting. A detailed positioning log, based on hourly observation by an objective monitor, may provide information as to whether positioning is a contributing factor in the vomiting. For instance, on 1/13/10, it was recorded that he vomited while being bathed. Positioning during bathing may have been an issue. At the time of the review, his nutritional state was at risk, as well as his quality of life. However, there appeared to be lack of continued searching to determine a cause for the repeated vomiting, as well as attempts at successful treatments, either medical or surgical. This individual may require several different consultations to ensure all potential sources of vomiting and all potential treatments have been diligently considered. ▪ Individual #294 had a history of recurrent vomiting associated with a large number of reflux events. A PEG tube was placed on 9/11/09. Since that time he has continued to have difficulties. On 12/18/09, he vomited, and then developed a productive cough and wheezing. On 3/4/10, he vomited a large amount of emesis. On 3/24/10, he vomited a large amount of watery formula. On 4/11/10, he had emesis followed by hypoxia. On 5/4/10, he vomited, and then began wheezing, and subsequently was diagnosed with pneumonia. On 6/15/10, he vomited a moderate amount of formula after being put to bed. On 6/19/10, he vomited a large amount of undigested formula. He developed respiratory distress with wheezing on 6/23/10, and was found to have left lower lobe pneumonia. On 7/11/10, he had mucous emesis due to putting his fingers in his mouth, on 7/12/10, he vomited phlegm like emesis, on 7/18/10, he vomited a large amount of formula emesis, on 7/22/10, he vomited a large amount of formula yellow colored emesis, and on 8/4/10, he vomited a small amount. However, there was little indication that the cause and the cure of the vomiting were being pursued. With a history of GERD, predating the PEG tube, it is likely many of the vomiting episodes are due to worsening GERD, which may be exacerbated by lying flat. Wheezing and bronchospasm also is associated with aspiration of gastric contents. It is recommended that he be seen by a gastroenterologist, for an upper gastrointestinal (GI) endoscopy or other procedure to rule in or out pathology, such as a Barrett's esophagus. Worsening GERD may be resolved with a Nissen fundoplication and J-tube placement. A log of positioning should be kept, including monitored every one to two hours to determine what his actual position is in relation to his formula feeding and his vomiting. An aggressive diagnostic work-up is indicated to resolve this issue. ▪ Individual #431 had several episodes of vomiting which suggested positioning	

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		was a problem or she was having severe reflux with small amounts of gastric secretions reported as emesis. Although she had other problems mentioned, there was some increased vomiting associated with bathing. A 12/24/09 note indicated: "appeared to have yellowish color drainage from mouth." A 1/20/10 note indicated "staff report vomit small amount yellowish secretions during bath." On 3/24/10, it was written: "was getting ready for discharge when [she] vomited, …Chest x-ray with left lower lobe infiltrate." On 3/26/10, the record indicated: "one episode of emesis, aspiration pneumonia improving." On 3/31/10, the record indicated: "aspiration pneumonia, with persistent hypoxia." On 4/1/10, there was the statement recorded: "[Individual #431] to bed, emesis mod amount yellow." On 4/5/10, there was a note: "returned home via wheelchair accompanied by staff post Infirmary stay for pneumonia…" On 4/9/10, it was recorded: "vomited moderate amount while being bathed. On side at time of emesis." On 4/10/10, the record indicated: "small amount of yellowish emesis noted on pillow." On 4/12/10, it was documented: "small amount of emesis at bath time x2." On 4/12/10, the record stated: "follow up Infirmary sta. doing well. One episode emesis. ….few scattered chronic. Right base. Aspiration pneumonia, improved." On 4/19/10, there was a note stating "sm[all] amt yellow curdled formula with clear emesis noted on pillow case. Remains positioned on side with head of stretcher elevated." On 5/17/10, it was recorded: "staff report vomit small amount yellow emesis during bathing." The repeated episodes of emesis with bathing suggested a positional issue. She was likely being placed flat, on her back or side, during bathing, which would allow potential severe GERD to occur with subsequent aspiration. In the meantime, she had a number of other health problems, but taking note that there were repeatable events potentially associated with lying flat suggested the need for aggressive evaluation for GERD. She may benefit from a J-tube or Nissen fundoplication, or changing her feeding orders (if she is bolus, to change to continuous). However, the first step is consistent monitoring to ensure staff do not lay her flat, even when bathing. This simple step may be adequate to treat many of her episodes of emesis. ▪ Individual #281 had a long history of GERD, and a G-tube and Nissen fundoplication were placed on 8/24/2000. He also had reactive airway disease/asthma. On 3/20/10, he had vomiting and fever. The emesis was described as dark brown. His G-tube was placed to drainage and another 300 cubic centimeters (cc) of dark brown drainage were collected. He was seen at the ER, and returned. It would have been helpful if information on positioning were recorded. If by him lying flat while in bed, or bathing, or other activity reactive airways disease were exacerbated, this would suggest GERD was a significant precipitant of the reactive airways disease. He was on an intermittent feeding schedule through the G-tube, and if GERD was a concern, going at a	

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		slower rate continuously may be more appropriate. Considering his history, reactive airways disease can be sequelae of GERD. With his episode of vomiting (vomited six times), one would need to determine if the fundoplication was still intact or had unwrapped and if so, whether it needed further intervention/ revision. Further, dark brown emesis may suggest some esophagitis, gastritis, or ulcer condition, which can aggravate vomiting. He was on Zantac at the time, which may be less effective than a proton pump inhibitor if he had esophagitis, gastritis, or a gastric/peptic ulcer. However, there was no information that further evaluation was completed or scheduled, such as an upper gastrointestinal series, or consulting a gastroenterologist for any of these issues. ▪ Individual #10 had a history of repeated pneumonias. He had a G-tube and a Nissen fundoplication. With continued bouts of pneumonia, further evaluation to determine the presence of GERD was indicated. This may include testing to ensure the fundoplication is functioning optimally, and if not, considering a revision of the fundoplication. Other options include a possible J-tube placement, as well as reducing the formula rate from intermittent to continuous, observations and monitoring to ensure his head is elevated at all times, even when bathing, or reclining, etc. However, unless further aggressive steps are taken, he is likely to continue with repeated pneumonias. ▪ Individual #317 had a PEG tube placed 10/1/98 for progressive dysphagia and weight loss. On 3/22/10, she was admitted to the Infirmary for fever, dehydration, vomiting, hypoxia and tachypnea. She did not improve, and was transferred to the hospital on 3/26/10. She had bilateral pneumonia. She returned to the Infirmary on 4/1/10, and to her home on 4/6/10. If further episodes of vomiting occur in which pneumonia develops, then a work-up for GERD should be considered. Given her medically fragile state, it may be important to complete a work-up for GERD before any further pulmonary complications occur. ▪ Individual #492 had a gastrostomy tube placed on 1/17/88. He also had a diagnosis of GERD dating from 1991. It was noted that his hemoglobin was increased and the consultant noted that his oxygen saturation at the time was only 91 percent, and that he might have had chronic hypoxia due to recurrent pneumonitis from aspiration. On 5/7/10, he vomited a moderate amount of formula. On 5/17/10, he had episodes of hypoxia and was found to have left lower lobe pneumonia. On 5/18/10, he was noted to be lying in bed, calm and in no respiratory distress. Rhonchi were heard in the upper part of both lungs. His oxygen saturation was 90 percent. He responded well to a nebulizer treatment with improvement in oxygen saturation to 94 percent, and a reduction of rhonchi. Unfortunately, there was no description of his position, specifically whether his head was elevated or not. This would be an important aspect of documentation in the case of pneumonias and dysphagia with an individual with	

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		a feeding tube. He returned home from the Infirmary on 5/20/10. He then developed hypoxia and respiratory distress on 6/4/10, and was transferred to the hospital. He was found to have his entire left lung opacified. He returned to the ABSSLC Infirmary on 6/9/10, and was discharged to his home on 6/17/10. It is recommended that his GERD be evaluated further or treated with a J-tube and Nissen fundoplication. Close monitoring of his positioning is also an important aspect of his care. However, there seemed to be no next step as to what could be causing his chronic aspiration and repeated pneumonias. ▪ Individual #20 had a G-tube placed in 7/1991. He also had a history of erosive esophagitis, hiatal hernia, and was diagnosed with a Barrett's esophagus by EGD on 9/10/95. On 2/8/10, he vomited a moderate amount of formula colored emesis. On 2/9/10, he vomited a small amount of brown liquid, and the G-tube was placed to drainage. More than 500 cc were drained. On 2/10/10, it was noted that he "still had nocturnal vomiting when laying in bed." At that time, it was recommended to provide more concentrated formula with decreased volume so the pump could be turned off periodically, and to increase the head of his bed to forty-five degrees. On 2/11/10, he vomited a moderate amount of formula. On 2/13/10, he vomited twice. He then had a Hepatobiliary Iminodiacetic Acid (HIDA) scan to rule out gall bladder pathology (results were reported as no gall bladder activity suggestive of acute cholecystitis). On 2/18/10, he vomited while lying in bed. Several months later, on 6/16/10, he was found to have a small amount of emesis on his bed sheets. On 7/5/10, it was reported that he had a small amount of formula emesis while bathing. The earlier history, as well as the Barrett's esophagus, along with the frequent vomiting, at times associated with lying in bed or while bathing, suggests severe GERD that remains untreated. It is recommended that he be reviewed for a J-tube and/or Nissen fundoplication. With his history of Barrett's esophagus, a repeat EGD would be appropriate if not done in the recent past. ▪ Individual #145 had a history of pica, and also a PEG tube being placed on 9/10/09 for dysphagia, and replaced with a Mickey button on 10/22/09. His formula was by slow bolus, and additionally he was ordered a Frazier Water Protocol. On 10/5/09, he was noted to spit up a quarter size amount of formula. On 11/5/09, his coughing with the Frazier Water Protocol was discussed at his PST meeting. On 11/11/09, he vomited after feeding and medication administration. On 11/23/09, he was observed to have wheezing. On 1/22/10, he was found to have blue glitter in his stool. It was documented that he ate some glitter the prior week in the day room, but this was not reported until it was noted in his bowel movement. On 4/9/10, he was noted to have coughing with wheezing. On 8/1/10, he had coughing with formula colored phlegm. His history suggests he may be developing severe GERD, especially with formula colored phlegm, and vomiting after feeding, but also episodes of wheezing which	

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		may be due to aspiration following severe reflux. Based on the documentation provided, it did not appear that testing was being completed to rule these in or out. Of additional significant concern, staff did not report he ate some inedibles. Although blue glitter would not cause an obstruction, it may have toxic contents, and the staff should have alerted the health care team. However, it also highlighted staff's lack of knowledge of pica, and the severe sequelae it could potentially have in this population. It is recommended that there be a policy developed for reporting the eating of inedibles, and that staff be trained concerning the seriousness of pica. ▪ Individual #311 had a G-tube placed along with a Nissen fundoplication in 1995. He also was found to have a sigmoid volvulus relieved by colonoscopic decompression on 2/2/10. He had a history of hand mouthing including: on 1/29/10, and 1/31/10 with possible attempts to vomit, followed by the diagnosis and treatment of his volvulus; hand mouthing with gagging on 6/7/10, at which time his G-tube was drained of 1000 milliliters (ml) and a large amount of air; on 6/10/10 with hand mouthing; and on 6/11/10, self-induced vomiting at which time his G-tube was drained of 300 ml. Such behaviors were his attempts to relieve discomfort, and this may be from esophagitis, gastritis, hiatal hernia, abdominal distention, or other etiology. His Nissen fundoplication may be unwrapped, or there are other possibilities for his behavior demonstrating discomfort. However, there was no EGD or other procedure to assure that there was not gastritis or esophagitis, etc. He was not on a proton pump inhibitor, although he was on Tums three times a day. If he repeatedly developed gastric distention and aerophagia or other cause for stomach gaseous distention, a J-tube may relieve some of his symptoms. However, the first step would be a thorough evaluation. From the "January – June 2010 Pneumonia Listing (aspiration pneumonia, pneumonia)," it was documented that there were 10 aspiration pneumonias and 41 pneumonias during this time period. For those that aspirated, three were on a pureed diet, five had a G-tube, and one had a J-tube. For those diagnosed with pneumonia, seven were on a ground-textured diet, eleven were on a pureed diet, 20 had G-tubes, and two had J-tubes. It is recommended that an additional data field indicating the level of thickening of liquids be added. For those on special diets, such as ground or pureed texture, and a thickened liquid at any level (nectar, honey, pudding, etc.), then a recent fluoroscopic swallow study should be completed to ensure the dysphagia is not worsening, and to guide the physician and staff in the safest texture of food for that individual. That three out of the ten individuals who had had aspiration pneumonias were on a pureed diet suggested the need for further investigation. The information that the individuals were on a pureed diets	

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		indicated chewing or swallowing problems (the reports did not indicate whether thickening was added to the fluids), and would make them higher risk for aspiration. That the individuals on pureed diet developed aspiration pneumonia suggested dysphagia, and need for further evaluation to prevent reoccurrences. The level of training and monitoring of direct support professionals is essential in the health and safety of anyone with dysphagia. The correct diet needs to be served, and the liquids offered need to have the correct amount of thickening for the meal to be successful. Staff need to be trained that this is a critical step. Unit administration also needs to monitor dining plans, and ensure they are being implemented correctly. If dining is not monitored consistently and constantly, direct support professionals will not consider it as a task that needs to be completed without error every time. Many of these areas would fall under the PNMT responsibilities with regard to dysphagia care and training of staff. This is discussed further below with regard to Section O of the SA. Five out of ten individuals who had had aspiration pneumonias had G-tubes in place. That half had feeding tubes suggests the need to review the reason for the high correlation of feeding tubes and aspiration pneumonia, and the contributing causes. For those that aspirated, GERD would need to be ruled out, or treated, as a cause of significant comorbid condition. Focus should be on positioning, to always ensure the individual's head is elevated, not only in bed when resting, but in bathing, and when in a recliner, etc. Monitoring of the positioning in the homes should be routine and unannounced and occur on all shifts. Again, if the unit administration is seen as monitoring positioning around the clock, then the direct support professionals will begin to understand the importance of this aspect of care. As an additional recommendation, for those aspirating with a G-tube, changing from a bolus feeding to a continuous/cyclical feeding may also reduce the risk of reflux. Continuous feeding would allow a low rate of formula administration per hour and minimize the volume in the stomach that may be refluxed at any point in time, an additional risk lowering technique. If GERD became a significant contributing cause of aspiration pneumonias despite the above steps being taken, then a Nissen fundoplication and or a J-tube might be helpful in reducing the risk of further aspiration. Positioning still is critical even with these procedures in place. If a J-tube is associated with aspiration pneumonia, then the formula orders generally need to be reviewed. Any bolus to the jejunum can create cramping and pain, which can lead to nausea and vomiting. Consequently, bolus of formula or fluids is not recommended with J-tubes. Formula feeding to the jejunum is known to increase gastric secretions, so emesis and aspiration could occur despite the individual being NPO. Continuous feeding is recommended through a J-tube if intermittent or cyclical feedings	

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		are problematic as less formula per hour over a longer time period may be better tolerated than over a shortened timeframe. Because of the discomfort associated with bolus administration, policies/procedures need to be developed and implemented to ensure bolus feedings are not being done through J-tubes. Also, procedures should address the need for caution when providing water flushes and water hydration via a flush or bolus with the J-tube. Water flushes with medication are imperative, but the volume should be reviewed so as not to cause jejunal distention and cramping. These same considerations also would apply for those individuals with pneumonias, even when the pneumonia is not diagnosed as aspiration pneumonia. Often, it is not clear as to the etiology of the pneumonia. However, if there are diagnoses of dysphagia, or GERD, then there is an increased risk this was the initial cause or contributing factor. In such cases, those individuals with textured diets and thickened liquids, as well as those with G or J-tubes should also be reviewed, following the same recommendations as those suggested for individuals having a diagnosis of aspiration pneumonia. Medical care would be enhanced and standardized if a clinical pathway/guideline was developed outlining when a physician should order the next step in diagnostic testing, or in treatment, either medical or surgical. An aggressive approach is needed throughout the pathway. For instance, after every new pneumonia, there should be the expectation of taking the next step, rather than waiting for several months or for several more pneumonias to occur with deterioration in health and increased scarring of the lungs. There were many deaths associated with pulmonary causes, including pneumonia and aspiration pneumonia (60 percent of deaths between 2/3/10 and 6/30/10 were due to acute respiratory illness), and many more with recent pneumonias and aspiration pneumonias. Some individuals had developed severe complications, and some had died with respiratory sequelae, when all options may not have been methodically considered. This area should be a priority area of focus and treated aggressively. With the frequency of aspiration pneumonias and dysphagia and GERD at ABSSLC, it is concerning that there had been neither G-tubes nor J-tubes placed since January 2010. Additionally, there needed to be a review and creation or revision in the policy concerning enteral feeding tubes, with attention to frequency of changing, clogging, and other complications, as well as care of the stoma site. Some examples of the issues identified included: ▪ Individual #431 was noted to have the following events: on 4/20/10, G-tube clogged; replaced on 5/1/10 monthly G-tube changed; on 6/3/10 monthly G-tube changed; on 6/14/10, G-tube plugged; replaced on 6/20/10, G-tube clogged; and on 7/1/10, monthly G-tube changed. There were two issues with this case. One was the number of times the tube was clogged. The Medical Department, along with nursing, and potentially pharmacy, need to review and	

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		determine the cause, then provide in-service training or revise the policy to provide guidance on how to maintain a G-tube so that it does not clog, or once clogged, the steps to be taken to resolve the clog. The second concern was the lack of ability to change the schedule for routine changes in order to meet the needs of the individual. The tube was changed monthly, regardless of if it had been changed a few days earlier. ▪ Individual #10 had his G-tube changed routinely on 5/1/10. Then on 5/23/10, for reasons described as "looking like needs to be changed," it was changed, and the nurse did not document further as to the reason. On 5/28/10, the stoma site was noted to be red with small amounts of blood and leakage from the stoma. On 6/2/10, while receiving routine stoma care, the G-tube "just came out. The bulb was burst." ▪ Individual #282 had a G-tube changed on 10/23/09, as the tube had clogged. It then was changed on 11/4/09 due to Boniva administration protocol. As part of the monthly schedule on 7/7/10. It was noted to be clogged, and was changed on 7/23/10. It again clogged on 7/28/10 and was changed again. Additionally, on 7/26/10, the J stoma site was described as "after removing numerous layers of gauze which was saturated by yellow liquid this nurse noted very excoriated J stoma and surrounding skin with the greatest excoriation at stoma and radiating approximately 3-4 inches." ▪ Individual #208 had the following events documented: J-tube out 10/30/09; 11/2/09 J-tube replaced; J-tube came out 12/2/09; patient laying in bed with J-tube completely out 12/5/09; J-tube dislodged on 1/18/10; coughed out J-tube on 3/16/10; and J-tube came out during dressing change 6/12/10. ▪ On 12/21/09, Individual #322 was noted to have "something black" in his G-tube that looked like mold. The G-tube was changed at 6:15 a.m., but it was recorded "while trying to remove tube out, had some difficulty removing it. Gently worked G-tube out." By 7:15 a.m., it was observed that there was dried dark red/brown drainage along with mucous drainage. By 8:45 a.m., the drainage had cleared. ▪ Individual #294 had his Mickey bulb changed on 4/23/10. There was some difficulty with the procedure. He developed an ecchymosis around the stoma site with mild erythema. On 7/5/10, the Mickey tube was found to be leaking and required changing. There also needed to be a system to check physician/dentist orders for PO diets/ medications when the individual is fed by tube. Issues identified included: ▪ The case of Individual #161 was already mentioned. Specifically, on 7/17/09, there was an order for a protein supplement to be given by mouth, as he had developed pressure induced skin breakdown over his sacrum. The PCP became aware of the order on 7/20/09, and stopped all orders for PO feedings and	

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		medication; his G-tube was to be used for all intake. However, the nurse did not discontinue the PO order on the MAR on 7/20/09. As most staff were aware he was to have nothing by mouth (NPO), it is not certain if any staff, particularly any new or covering staff, may have provided him the PO supplement. ▪ An additional case was individual #281, who was placed on a post tooth extraction soft diet to increase as tolerated on 1/26/10. However, he was fed by a G-tube, but the diet ordered was not discontinued or Jevity started via his G-tube until 2/1/10. Although the nursing staff should know and understand not to start PO diets on tube fed individuals who are to receive NPO, new staff or staff in training may not have that knowledge base and could cause harm to the individual. Choking on food or fluid had occurred several times per month on campus. This is discussed in further detail below with regard to Section O of the SA. The following provides an example of an individual with complex issues affecting her safety when eating: ▪ Individual #241 choked during her lunch meal. Staff had attempted to redirect her from eating too fast and taking too large a bite. She started coughing, face turned red, was offered fluid, and recovered. The Occupational Therapist (OT) evaluated her on 12/23/09, and found that she often swallowed chopped foods whole or very slightly chewed. She also had significant oral residue at the back and sides of her tongue that did not consistently clear with liquids. It was recommended that her diet be changed to all ground. The PST met on 1/5/10, but discussed her high risk issue of her urinary tract infections, not her choking episode and change in diet. On 3/27/10, she developed fever, vomiting, and hypoxia. She had a weak cough. Of note, Sinemet had been started 1/15/10 for her Parkinson's disease. She was diagnosed with left lower lobe pneumonia. On 4/9/10, she choked on juice and recovered. On 4/9/10, OT assessed her eating. She could not maneuver her ground texture and pureed food was offered. She ate five percent of her meal, and began coughing. Her diet was changed to all liquid during which time an MBS was scheduled. On 4/12/10, she had a coughing spell after her liquid meal. The MBS did not indicate penetration or aspiration, and a ground diet was resumed. Several orders were written on 4/19/10, which included to drain liquid from the ground food, staff were to feed her, staff were to use small spoonfuls, ensure upright position in dining chair, to feed very slowly and to wait for her to swallow before offering another spoonful, to encourage independence in fluids, and for her to drink sips from her mug every two to three spoonfuls of food. On 6/2/10, she choked on ground beef, as described by nursing staff on site at the time. The Abdominal Thrust was required and a large amount of ground beef was expelled. The OT again observed her on 6/2/10, and believed her choking spells were due to the	

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		progression of her Parkinson's disease and recent increase in medications. On chest x-ray, she had a right lower lobe infiltrate. On 6/20/10, she choked on Kool-Aid and recovered. On 6/25/10, she choked on chopped up spaghetti, and an Abdominal Thrust was used to expel the food forcefully. There was no comment as to whether the chopped spaghetti followed the ground food diet recommendation. On 6/29/10, she saw a gastroenterologist who assessed her to have an esophageal obstruction, aspiration pneumonitis, and Parkinson's disease. An EGD revealed an esophageal-gastric junction stenosis that was dilated, mild nonerosive esophagitis, and gastritis, as well as H. pylori that was treated. She was reevaluated by OT on 7/12/10, and noted that she had a delayed swallow with heavy oral residue after swallowing, and fatigued as the meal progressed. It was recommended that she be offered pureed diet with five smaller meals a day rather than three to help decrease her fatigue. On 7/17/10, she choked eating supper. This represents a complex case of repeated choking in someone with Parkinson's disease, as well as someone with unsafe eating habits, and a history of esophageal stenosis recently treated. It is recommended that the NMT follow this individual closely, and work closely with the direct support professionals, nurses, and PCP. The NMT will need to ensure she is being fed the appropriate textured diet at a proper pace to meet her needs, as well as ensure optimal positioning. Because of the complexity of her case, meal intake and fluid intake should be recorded in a log, with a description of any behaviors, positional concerns, coughing episodes, etc. in order to collect baseline information. A detailed clinical pathway guiding several disciplines would ensure there is timely treatment and work-up of this problem. Documentation in the medical record for those transferred to the hospital was discussed with the Medical Director. For those individuals with acute decompensation, the primary care practitioner would not logistically be able to write a transfer note and send it with the individual. In such cases, the nurse was supposed to record important clinical findings. There would be one or more sets of vital signs. If the primary care practitioner was on site, they would write a note and call the ER to provide information. If he/she was not on site, then the nurse would contact the ER and provide information. A packet of information was sent to the hospital with each individual. There was a checklist called the "Records Verification Checklist for Hospitalization," and it listed all the pertinent documents the hospital would require to care for the individual. The person providing the information to the hospital as well as the person at the hospital receiving the packet signed it. During the hospitalization, the nurse liaison from ABSSLC rounded daily at the hospital and obtained an update on all inpatients from ABSSLC. Upon return to ABSSLC, a typed entry would be made in the integrated progress notes. The nurse liaison also sent	

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		information by email to alert the QMRP and others at ABSSLC in need of knowing the daily progress of the individual at the hospital. Upon hospital discharge, a copy of the history and physical exam, progress notes, laboratory test results and radiographic test results, and procedure reports were routinely obtained. However, the discharge summary would not necessarily arrive with the individual, and subsequently would not be readily obtained, even after requests were made. When the individual returned from the hospital, the primary care practitioner completed a clinical assessment, reviewed the packet of information from the hospital, and was responsible to write a post hospital progress note, usually within 12 hours of readmission. Nursing also was responsible to complete an assessment, especially a head-to-toe skin assessment. Also, there was supposed to be documentation made when the primary care practitioner contacted the hospital attending physician and discussed the case. The content of that conversation was recorded. Although there was an expectation of physician-to-physician communication at the time of the hospital discharge, it would not always occur. Likewise, a hospital nurse was expected to contact the nurse at ABSSLC. When this did not occur, then the ABSSLC nurse called the hospital. The system did not always work, as occasionally, individuals returned from the hospital when the primary care physician was unaware, but a system was in place. <u>Routine Medical Care</u> Based on record review, the annual medical summary and physical examination evaluation were up-to-date for the following individuals: Individual #431 on 10/13/09, Individual #281 on 1/13/10, Individual #10 on 3/9/10, Individual #59 on 2/8/10, Individual #100 on 8/17/09, Individual #282 on 2/10/10, Individual #208 on 1/25/10, Individual #361 on 4/13/10, Individual #322 on 3/30/10, Individual #458 on 5/18/10, Individual #90 on 2/16/10, Individual #357 on 4/9/10, Individual #317 on 4/12/10, Individual #511 on 6/2/10, Individual #294 on 9/1/09, Individual #492 on 9/3/09, Individual #311 on 2/24/10, Individual #145 on 10/20/09, and Individual #241 on 6/7/10. The most recent annual summary and physical examination evaluation submitted for Individual #20 on 6/17/09 and was the only outdated one. Compliance was 19/20 (95%). Vaccination status was reviewed to determine the level of routine preventive care. The records were reviewed for the influenza vaccination and H1N1 vaccination. All 20 of the 20 individuals reviewed (100%) had timely influenza vaccination. Eighteen of 20 (90%) had documentation of H1N1 vaccination in the medical record. More specifically:	

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		Individual #431 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #281 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #10 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #59 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/8/09 (not recorded on Nursing assessment of 4/28/10, but documented in the medical record.); Individual #100 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/9/09; Individual #282 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/8/09; Individual #208 received influenza vaccination on 10/12/09, and H1N1 vaccination on 12/7/09; Individual #361 received influenza vaccination on 10/5/09, and H1N1 vaccination on 12/7/09 (not recorded on Nursing assessment of 2/1/10, but documented in the medical record); Individual #322 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #458 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #90 received influenza vaccination on 12/09, and H1N1 vaccination on 12/09; Individual #357 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/10/09; Individual #317 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/8/09; Individual #511 received influenza vaccination on 10/2/09, and H1N1 vaccination on 12/15/09; Individual #294 received influenza vaccination on 12/11/09, and H1N1 vaccination on 12/9/09; Individual #492 received influenza vaccination on 10/5/09, and H1N1 vaccination on 12/7/09 (not recorded on nursing assessment of 5/13/10, but documented in the medical record); Individual #311 received influenza vaccination on 10/1/09, and H1N1 vaccination ordered 12/8/10, but could not find documentation in the nursing assessment of 6/8/10, and could not find documentation of administration in the progress notes); Individual #20 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/9/09; Individual #145 received influenza vaccination on 10/14/09, and H1N1 vaccination ordered 12/8/09, but not recorded in the progress notes as given and not recorded in the Nursing Assessment of 5/14/10; and Individual #241 received influenza vaccination on 10/1/09, and H1N1 vaccination on 12/8/10. <u>Emergency Medical Drills</u> Since the baseline review, ABSSLC had revised it policy addressing Medical Emergency Response and the Medical Emergency Drill Checklist. The policy indicated that drills were to be conducted monthly in each of the homes on every shift. The CNE reported that in conjunction with the Medical Emergency Drills, nurses will be observed demonstrating the use of the emergency equipment. In addition, the CNE reported that competency-based training had been provided to a majority of the nurses (187). However, in response to the request for the curriculum for this training, only a copy of the Mock Emergency Drill form was provided. Thus, the Review Team could not assess the quality of the training. However, training rosters were provided.	

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		From review of ABSSLC's Mock Medical Emergency Drills (161) from February through June 2010, the Facility appeared to be conducting drills on a monthly basis and on the various shifts. Of concern, the drills that were conducted on the same day were usually within 10 to 15 minutes of each other. For example, the drills conducted on 5/31/10 were documented to have taken place at 11:30 p.m., 11:45 p.m., and 11:55 p.m. Conducting emergency drills that take less than 10 minutes does not seem like enough time to assess adequately the Facility's emergency systems. This may be the reason why only eight of the drills reviewed out of 161 included some type of comment. None included any recommendations. When evaluating emergency systems, it would be rare that that there would not be some additional recommendations regarding the review of the drill procedures. Based on the documentation reviewed, it appeared that conducting the emergency medical drills had become merely a task rather than an opportunity to assess, evaluate, and improve a critical system for the individuals at ABSSLC. The few comments found on the drills indicated that there were some issues, such as: ▪ Ambu bag falls apart during use; ▪ Nasal cannula tubing not in red bag; ▪ Staff did not know how to use Automatic External Defibrillator (AED); ▪ HSS refused to participate and walked away; ▪ LVN went to get emergency bag and returned without it ▪ No backboard at home; ▪ Ambu bag is broken; ▪ Staff continued to sit in their chairs and would not get up and perform in the drill; and ▪ "Worst response I have ever witnessed during a code drill on this campus! Staff was not cooperative at all. [Staff Member] stated I am not doing any CPR. Lead staff aware, left room." There was no indication that any corrective actions were taken for the issues listed above. Consistent with the baseline findings, ABSSLC had no system currently in place to document that issues found during the emergency drills were timely and appropriately addressed. In addition, there was no system in place for regular review of the Facility's medical emergency procedures or analysis of the drills regarding trends that generated corrective actions and outcomes. It appeared that there had been no review of the drills conducted at all by either the Nursing Department or Medical Department. The CNE reported that the Facility's leadership was going to be looking at the emergency system, but this had not yet been implemented. The purpose of conducting regular medical emergency drills is to identify strengths and weaknesses of the Facility's response to emergencies by continuously assessing the process as well as the staffs' knowledge and competency executing emergency procedures. The Facility needs to develop and implement a system for reviewing and analyzing emergency procedures and data	

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		generated from the emergency medical drills. Consistent with the baseline findings, the review of the drills found that the Facility did not incorporate the actual use of the emergency equipment during drills. Although staff brought the equipment to the drills, they did not actually practice with it. This is essential and ensures that when an emergency arises, the nurses will be familiar with the equipment that would be used. Observations of emergency equipment use by staff in the Infirmary and Building 6521 found that there was no list of the equipment contained in the red bags that were taken to emergencies. In addition, the alarm was not operational for the AED in the Infirmary. The nurses on both units were able to appropriately demonstrate the use of the oxygen, suction machine, and AED. However, problems were found in that the backup suction machine and the portable suction machines were not being checked. In addition, there were a number of blanks on the emergency equipment check log indicating that the oxygen had not been consistently checked. In addition, the forms used by the units were very difficult to read, and to determine how often the equipment was checked and how the equipment was being checked. These forms should be revised so that the information regarding the checking and testing of the Facility's emergency equipment is clearly documented. The Facility needs to continue focusing on implementing improvements to the emergency system. The initials efforts that the Facility was making appeared to be promising, however there was much more work that needed to be done to ensure that staff are competent in executing emergency procedures.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	There was no medical review system that consisted of a non-Facility physician that provided peer case review, as part of a quality improvement program. As discussed above with regard to Section L.1 of the SA, an important part of a medical review system at the Facility includes mortality reviews. Historically, at ABSSLC the medical and nursing departments had completed such reviews. An outside peer review process to ensure objectivity of focus and conclusions would be an essential component of the medical review system required by the SA. As an important but separate component of non-Facility physician review, a contract has been recently signed with an MD-patient safety organization, Quantos, Inc., based in California. They will be conducting mortality reviews of ABSSLC death cases. This is an important step in meeting the requirements of the SA.	Noncompliance
L3	Commencing within six months of the Effective Date hereof and with	There was no development of a quality improvement program or process to determine the quality of medical services. Once medical direction is provided in the form of clinical	Noncompliance

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	full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	guidelines/pathways and other routes of guidance, aspects of these guidelines can be used as specific tools to measure compliance with the expectations of the clinical guideline or pathway. Sampling of medical records to determine primary care practitioner compliance with the guidelines could then be completed, data collected, trends recognized, and actions developed and implemented to improve compliance. Until the clinical pathways/guidelines are developed, the POI may be of assistance in providing measurable outcomes. However, there would need to be some guidance in determining what to measure that would reflect quality medical services, and then how to measure the quality so that it accurately reflects what is occurring. Once data is collected and analyzed, it is important for the data to be utilized to assist in changing and improving the measurable outcomes. Until this occurs, the system has not completed the quality improvement cycle. There would need to be demonstration that the system is identifying issues, analysis is occurring to identify underlying causes, and practical next steps are being developed and implemented to effectuate change, and monitoring is being conducted to measure that the actions are having the desired impact.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The current medical manual was completed in 1990. Several of the policies in the manual dated much earlier. Consistent with the requirements of the SA, the State Office released new draft health care guidelines (dating from May 2009). The challenge for the Medical Director was to incorporate these into the medical manual, as well as to remove old policies and procedures that no longer applied. One policy that had recently been reviewed and revised was in response to an ICF-MR survey in which there was concern that not enough pap smears were being completed. A "Cervical Cancer Risk Estimate" was researched at ABSSLC addressing the risk of cervical cancer. The Medical Director assessed the risk for each female residing at ABSSLC in order to provide guidance in screening for cervical cancer. The target population included those over 20 years of age. The PCP using specific criteria assessed risk. If the individual was not considered at risk according to the criteria outlined in the policy "Abilene State Supported Living Center Policy on Periodic Cervical Cancer Screening," then there was documentation by the PCP. This was part of the plan of correction to the ICF licensing survey. The risk was assessed at least once yearly at the time of the annual medical summary and physical exam, updated as needed and filed in the record. If needed, the individual was provided sedation for cooperation. Such issues as contractures, guardian consent, and behaviors were addressed. Two female primary care providers were assigned to complete pap smears and pelvic exams. Most gynecologic exams were completed at ABSSLC, but a local gynecologist followed those with complicated pathology, especially cancer.	Noncompliance

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		The Medical Director also wrote/updated the "Post Exposure Injury Policy," revised April 2010, as part of the Infection Control Manual. Pica is a health hazard that requires an interdisciplinary approach. The Medical Department needs to ensure standardization of the medical aspects of this care in the area of prevention and treatment. This should be done through a policy/clinical pathway. The following is an example of an individual for whom pica was not addressed adequately: ▪ Individual #458 did not have a diagnosis of pica listed on the CARE-DG-1 form, or on the active problem list, or inactive problem list of the annual medical summary and physical examination evaluation. On 11/5/09, soft plastic was found in her stool. She had a history of chewing on anything that was next to her mouth. These small pieces of black foam were from an old headrest in the relaxation room. A KUB (abdominal x-ray) was completed. She was placed on enhanced supervision, and staff were instructed to monitor for foreign objects in her stool. She did well, and then was found to have a rubber band in her stool on 11/23/09. There were no other findings or sequelae. As the medical policies and procedures manual is updated and implemented, many aspects of medical care will be impacted. Although many at the Facility have been diagnosed with osteoporosis and currently are on Boniva, at the time of the review, not all individuals eligible for preventive treatment of osteoporosis had been receiving optimal treatment. For example: ▪ Individual #59 was postmenopausal and most health recommendations suggest calcium supplementation, but this individual was not on any calcium supplement. Without standard expectations being clearly set forth, there were likely other individuals who should have been getting calcium supplements, but likewise were not getting it. A clinical pathway would provide guidance in outlining basic expectations of care concerning osteoporosis prevention that can be applied to those eligible for such treatment across the campus.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Infirmary rounds should be expanded to encompass a formal medical staff meeting each business day with minutes taken. These meetings should be designed to provide an opportunity for the medical team to review medical problems that occurred in the past 24 hours, so all physicians are aware of the current critical cases at the Facility. Such meetings also should provide opportunities for all physicians to share ideas on a variety of clinical issues, keep the Medical Director updated concerning the entire population, and allow the Medical Director to provide open and consistent guidance in clinical areas. Pharmacy and nursing staff should be invited to participate, depending on the

availability of staff in those departments.

2. Additional ethical and legal guidance should be sought in implementing the second qualifying condition for a DNR of "irreversible condition" in the context of the ID/DD population residing at ABSSLC
3. Once additional guidance has been obtained, members of the ABSSLC Ethics Committee be formally trained in the legal and ethical issues and requirements of the end of life decisions, such as DNR status, in order to assist the PCPs and the PSTs.
4. A clear policy outlining the steps of the DNR process should be created or updated, including the timeline of meetings of the PST, and the Ethics Committee. The Medical Director should consider cases in which the decision process was successfully completed, including cases in which the approach was methodical, thorough, and appropriate, in developing a blueprint or pathway for this sensitive issue. As a guideline, it is recommended that the medical record of anyone for whom a DNR has been instituted reflects that all possibilities have been pursued and ruled out, clearly defining that the individual is in inevitable decline for which hospice care can offer excellent palliative care.
5. The State Office should develop a policy that standardizes the DNR process across all SSLCs.
6. As decisions are made regarding individuals' DNR status, an outside opinion should be considered that would verify that the DNR status is appropriate to the individual. Examples of outside opinions include a physician not involved in the care of the individual, a representative from another state-operated facility, or an opinion from the local hospice agency.
7. PSTs and PCPs should be encouraged to review all current DNR orders to determine if the status remains appropriate, the qualifying conditions need to be updated or changed, or the order needs to be rescinded. For those individuals who are more unstable due to acute health care needs, the PSTs and PCPs should consider prioritizing the review if the semi-annual review is not in the immediate future.
8. The State Office should identify options for creating a mortality review process from which all can learn and apply new knowledge without the fear of legal discoverability. Such a system should ensure that mortality committee members are able to discuss openly areas of risk and plans for quality improvement within the SSLC.
9. Clinical death reviews should be improved. The following recommendations are offered to assist in this process:
    a. Mortality reviews should be completed in a timely manner. A brief medical or clinical review should occur with two to four weeks as a preliminary review. A more extensive multi-disciplinary review should then be scheduled within a few months, in order to ensure the autopsy report is available;
    b. All departments should be required to review their department involvement with the individual over a long span of time, if necessary obtaining peer review of that department through a sister facility;
    c. Mortality reviews should be used as a quality improvement tool and risk management tool for all departments;
    d. Mortality review reports should include recommendations to address any areas in which improvements should be considered and/or made. Each such recommendation should be considered carefully, and, as appropriate, action plans should be developed and implemented to address the recommendations. Such action plans should include action steps, person(s) responsible, anticipated outcomes, and timeframes for completion.
10. When there is a "code" called, there should be precise documentation of timing of events and personnel involved.
11. Direct support professionals should be provided further training on change in health status, such as what to observe, how to describe observations, and when to contact the nurse.
12. Threshold indicators should be developed and implemented for use in determining when an individual should be transferred to the hospital. These should be measurable criteria that can be used in every case. A related policy would be beneficial that outlines expected treatment prior to consideration of a transfer to the area hospital.
13. To avoid confusion, it is recommended that a policy describe the interaction of how hospice works at ABSSLC, as well as hospice involvement with family communication, decision-making, and expectations.
14. It is recommended that the clinical pharmacist review all medications given by J-tube to ensure the medications are clinically appropriate.
15. There is an urgent need for a clinical pathway for those with repeated aspiration from any cause (dysphagia, GERD, vomiting, etc.)
16. The Facility would benefit from other clinical pathways, to ensure consistency across campus and ensure there is no individual overlooked for a

particular concern. Pathways also should be developed for pica, osteoporosis, falls with fractures, and chronic constipation.

17. The nursing department and the homes should record positioning for those with a diagnosis or suspected diagnosis of dysphagia and GERD, especially recording the position at the time of emesis.
18. In addition, the nursing department is encouraged to develop a monitoring system for positioning, which makes continuous unannounced rounds and observes positions on all shifts, with focus on those with high risk diagnoses, such as dysphagia and GERD.
19. Tests and procedures that are ordered need to be tracked until completion. This should include the name of the test or procedure ordered, date completed, date report received, and date physician signed off on the result. The nurse assigned to that home should review any test or procedure that remains incomplete each 30 days, and take necessary action to ensure the test is completed.
20. It is recommended that when a fracture occurs, an interdisciplinary meeting be called to both plan for fracture care and to plan for prevention of another fracture.
21. It is recommended that there be a series of educational lectures provided to the PCPs and nursing department by specialists in the area or from a medical teaching program. Topics that would be beneficial include dysphagia, GERD, Barrett's esophagus, gastroparesis, colonic hypomotility, J-tube feeding and medication administration, etc.
22. Medical staff are encouraged to review the medical records longitudinally to note any trends such as vomiting while bathing or lying in bed, and act on these trends.
23. It is recommended that staff be trained on reporting the ingestion of inedible objects by the individuals, even if the items or liquid seem harmless. The staff need in-service training on pica and the potential serious complications of this behavior.
24. It is recommended that a policy on enteral tube care be created or revised, focusing on such problems as clogging of tubes, frequency of changing tubes, stoma site care, etc.
25. It is recommended that in the quarterly nursing assessment, the number of tube changes per month be recorded.
26. It is recommended that a nurse specializing in stoma care be available to assist with ostomy care of feeding tubes, and be consulted on complications of ostomy care.
27. The Medical Director, Nursing Department, and Pharmacy need to create a system which contraindicates a PO order for diet or supplement when the individual is NPO and on G or J-tube feedings.
28. It is recommended that the Medical Director update the Medical Department manual.
29. The Facility should develop and implement a system to ensure that:
    - The process of conducting emergency medical drills is a meaningful review of the medical emergency response system;
    - The Medical Emergency Drills include the use of the emergency equipment;
    - There is a policy/procedure outlining the levels of committee review for Medical Emergency Drills, actual Code Blues, and emergency procedures;
    - Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues;
    - Competency-based training continues to be provided regarding emergency procedures that include the use of the emergency equipment; and
    - Emergency equipment is checked and tested daily and clearly documented.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC's POI; o ABSSLC's Nursing Supplemental POI; o ABSSLC's Nursing Department Presentation Book; o Nursing QE data since February 2010, including Acute Injury/Illness, ER/Hospitalizations, Annual Nursing Assessments, HealthCare Plans, Nursing Documentation, Prevention, Quarterly Nursing Assessments, Seizure Management, Diabetes, Aging, GERD (gastro esophageal reflux disease), Hypertension, Incontinence and UTI (urinary tract infections), Bowel Management, Skin Integrity, Pain Management, and Psychotropic Medication; o ABSSLC's Nurse Manager Monitoring tool data from February through June 2010; o Corrective Action Plan, dated 5/1/10 addressing legibility regarding nurses' signatures for the nursing entries in the medical records; o The Nurses' Meeting minutes, meeting rosters, and handouts, dated 3/30/10, 4/1/10, 4/20/10, 4/22/10, 5/25/10, 5/26/10, 6/22/10, and 6/23/10; o Infection Control Committee meeting minutes, dated 4/25/10, and 7/8/10; o ABSSLC's nursing staffing vacancies; o Pharmacy and Therapeutic Committee minutes, dated 4/30/10; o Infection Control Manual, dated 7/14/10; o ABSSLC H1N1 Influenza 2009 After Action Report; o Post Exposure Process; o Post Exposure Injury Policy, revised April 2010; o Post Exposure Injury Procedures, revised April 2010; o ABSSLC Treatment Room Post-Exposure Injury Report form; o ABSSLC Employee Follow Up Post Exposure Testing Notes form; o Procedure for Distribution of Monthly Infection Report to Multidisciplinary Team; o Procedure for Communicable Disease Track; o Infection Control Monitoring Tool and data from 2/10 through 6/10; o Emails from Infection Control addressing Nursing Care Plans reviewed; o Infection Control course description for new employee orientation; o The medical records for the following individuals: Individual #322, Individual #10, Individual #411, Individual #545, Individual #119, Individual #134, Individual #435, Individual #337, Individual #234, Individual #324, Individual #281, Individual #12, Individual #126, Individual #186, Individual #385, Individual #208, Individual #162, Individual #510, Individual #71, Individual #518, Individual #324, Individual #378, Individual #257, Individual #150, Individual #364, Individual #284, Individual #152, Individual #229, Individual #7, Individual #26, Individual #531, Individual #362, Individual #439, Individual #418, Individual #267, Individual #424, Individual #163, Individual #402, Individual #30, Individual #483, Individual #61, Individual #74, Individual #308, Individual #438, Individual #544, Individual #545, Individual #140,

	Individual #405, Individual #365, Individual #397, Individual #370, Individual #165, Individual #12, Individual #327, Individual #180, Individual #345, Individual #521, Individual #139, Individual #123, Individual #205, Individual #213, Individual #13, Individual #253, Individual #262, Individual #228, Individual #470, Individual #534, Individual #76, Individual #154, Individual #303, Individual #505, Individual #272, Individual #491, Individual #8, Individual #108, Individual #226, Individual #106, Individual #229, Individual #387, Individual #227, Individual #81, Individual #188, Individual #276, Individual #526, Individual #355, Individual #274, Individual #132, Individual # 263, and Individual #156; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o ABSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary; o ABSSLC's Risk lists for health indicators; o Minutes of the Medication Error Committee, dated 3/3/10, 3/31/10, and 4/28/10; o The revised Comprehensive Nursing Assessment form, and Guidelines; o ABSSLC's medication variance data, from January through May 2010; and o Revised Medication Administration Observation form; ▪ **Interviews with**: o Jim Kluza, RN, BA, Chief Nurse Executive; o Mary White, RN, BSN, Quality Enhancement Nurse; o Krista Hamilton, RN, BSN, Infection Control Nurse; and o Marilyn Branson, RN, Infection Control Manager; ▪ **Observations of**: o Medication Administration in home 6500; and o HST meeting on 8/5/10
	Facility Self-Assessment: At the time of the review, the Facility was revising the POI to provide a description of the steps the Facility was taking to assess compliance with regard to the specific sections of the Settlement Agreement related to nursing care. Although the POI for ABSSLC did not include this component, the POI highlighted the commitment the State and the Facility had to the thoughtful implementation of the processes and systems needed to provide quality services. While ABSSLC indicated that it was in compliance with a number of areas in Section M of the SA, there was no data presented to support this, and the Monitoring Team found based on its review that these areas were not in substantial compliance. In order to come into substantial compliance, there are a number of foundational systems that will have to be solidly built before additional needed systems can be put in place. Also, quality, not just completion is the determining factor in appropriately assessing substantial compliance in most areas. After these foundational systems are built and the monitoring systems include the quality piece, it will necessary to provide data validating substantial compliance that includes the total

	population being reviewed (N), and the sample of that population audited (n) to yield a percent sample to indicate the relevance of the compliance scores. An adequate sample size also needs to be reviewed to ensure that the findings can be applied to the total population. Without this information, the Facility's data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured.
	Summary of Monitor's Assessment: Since the baseline review, ABSSLC continued to have adequate nursing staff, even with some vacancies. The Facility had reallocated one position, the Nurse Recruiter, to work part time with Quality Enhancement (QE), and the Hospital Nurse Liaison had also been assigned to assist the QE Department. At the time of the review, there was no plan regarding how long these positions would be assisting QE, or if these were permanent reallocations. The Facility had continued not to need the use of any agency nurses. ABSSLC's QE Nurse and Nursing Department had begun using the Monitoring Teams' review/monitoring tools in a number of areas. This system was in the initial stages, and the data generated from the auditing was not yet addressing the quality of the areas audited. Once the Facility has more experience with these tools, instructions will need to be developed for each monitoring tool. As these are developed, the Facility also will need to develop and implement a procedure for establishing inter-rater reliability at 85% or above. Consistent with the findings from the baseline review, there continued to be a number of significant problematic issues that were found regarding the nursing documentation addressing complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a status change, and of assessments prior to the transfer to an off-site medical center as well as upon return to the Facility. The Nursing Department was in the early stages of beginning to audit individuals with acute illness and requiring hospitalization. They were in the process of using the monitoring tools to assess the care and documentation, which should lead to the implementation of plans of correction to address the identified deficiencies. Also consistent with the baseline findings, there were significant problems found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, the State Office had modified the Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The implementation of the modified Comprehensive Assessment was reported to begin on 8/1/10, but it had not been implemented at the time of the review. In addition, the State Office had decided to use the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plans. Competency-based training had not yet been initiated for these areas. Since the baseline review, the Nursing Department was in the process of implementing some interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and the frequency of the medication observations for nurses was changed from annually to quarterly. Also, the

	Medical Director and Pharmacy staff now were involved in the Medication Error Committee. This collaboration should produce valuable assessments and corrective actions regarding the medication administration system. Although many of the systems were not in place addressing the requirements of the SA to meet substantial compliance, the Nursing Department demonstrated its commitment in moving forward. Many of system that had been implemented are detailed further in the sections below that address each of the requirements of Section M of the SA.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, and infection control. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the SA. <u>Staffing</u> As reported in the baseline report, ABSSLC continued to have adequate staffing of nurses. The department continued to have 82 positions allotted for RNs and 105 positions for LVNs, with two LVN and one RN vacancies as reported in the Supplemental POI. The Chief Nurse Executive reported that interviews already had been conducted for the RN position. Also, two additional RN positions recently were filled, and were scheduled to start on August 1, 2010. In addition, since the previous review, nursing coverage during the 4 p.m. to 12 a.m. shift consisted of four nurses. The CNE reported that he planned to increase nursing coverage on this shift to eight nurses through attrition. Since the previous review in February 2010, the Facility had reallocated one position, the Nurse Recruiter, to work part time with QE, and the Hospital Nurse Liaison also had been assigned to assist the QE Department. At the time of the review, there was no plan regarding how long these positions would be assisting QE, or if these were permanent reallocations. In the event these positions become permanent, the Facility would need to develop job descriptions/job duties addressing these newly allocated positions. Also, policies, procedures and/or protocols would need to be modified or developed addressing the integration of these positions into the QE Department. Since ABSSLC continued to maintain an adequate and consistent nursing staff from the previous review, the Facility had continued not to need the services of agencies to	Noncompliance

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		augment nursing staffing coverage. Also since the baseline review, the Facility continued to host two nursing students from the local area for clinical training, thus having a pool from which to recruit new nursing graduates. However, the CNE reported that given the challenging and medically complicated individuals at the Facility, he had been successful in hiring nurses with emergency and acute care experience. ABSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. At the time of the review, ABSSLC had a census of 452 individuals. The structure of the Facility's nursing services remained the same since the previous review: ▪ Five of the residential buildings had 24-hour nursing care, specifically buildings 6521, 6510, 6480, 6500, and the Infirmary. ▪ During the day, nurses were assigned to each building. During the night shift, the Facility utilized a Campus Nurse who made rounds, and covered the portions of the Facility that did not have 24-hour nursing. ▪ ABSSLC's nursing staffing assignments included 40 home nurses, 14 campus nurses, 13 Infirmary nurses and 11 direct care nurses. ▪ The Chief Nurse Executive continued to directly supervise the Hospital Nurse Liaison, Nurse Educator, the Infection Control Nurses, the Nurse Operations Officer, and six (6) nurse managers. ▪ The minimum nursing staffing requirements were based on a fixed number of nursing staff (RN and LVN) per specific Unit, but could be modified based on patient census, patient acuity, and staff workload related to individual or staff activities. <u>Quality Enhancement Efforts</u> Since the baseline review, the QE Nurse, the Nurse Recruiter, and the Hospital Liaison Nurse had begun using the Monitoring Teams' review/monitoring tools in a number of areas, including: Acute Injury/Illness, ER/Hospitalizations, Annual Nursing Assessments, Health Care Plans, Nursing Documentation, Prevention, Quarterly Nursing Assessments, Seizure Management, Diabetes, Aging, GERD, Hypertension, Incontinence and UTI, Bowel Management, Skin Integrity, Pain Management, and Psychotropic Medication. During the interview with the QE Nurse, she asked a number of specific questions about the items and scoring of the tools indicating that QE had been investing significant efforts to implement the tools. The QE Department continued to generate data regarding nursing from some of the tools that were in place during the baseline review, but these did not include items addressing quality. At the time of the most recent review, they were still in the initial stages of becoming familiar with and implementing the new monitoring tools. The QE Nurse reported that thus far, in the audits that had been implemented, they still were not	

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		adequately addressing the quality of the documentation. In order to adequately and consistently monitor all the areas required by the SA, instructions will need to be developed for each monitoring instrument. Once these are developed, the Facility will need to develop and implement a procedure for establishing inter-rater reliability at 85% or above. Clearly, the Facility was at the beginning stages of piloting and implementing a number of new monitoring systems. Continued efforts are needed to develop the processes necessary for the generating data that can be accurately interpreted, analyzed, and are reflective of the practices being measured. These include: ▪ Having instructions to accompany the tools; ▪ Providing the total the population being reviewed (N), and the sample of that population audited (n) to yield an adequate percent sample to indicate the relevance of the compliance scores; ▪ Having an adequate sample size; and ▪ Assessing for quality A review of the data from the Nurse Manager Monitoring tools from February through June 2010 found that the tools that the Nurse Managers were using did not contain all the items that the tools the Facility adopted from the Monitoring Teams did, so they were not in alignment with the SA. In addition, there was a lack of consistency between the compliance scoring noted and the comments listed on the tools. For example, the auditors frequently found problematic issues related to lack of follow-up for acute illnesses and injuries, and documented them in the comment section. However, the data on the monitoring tool indicated the item was in compliance. Based on this reviewer's findings regarding nursing documentation, the quality of the nursing documentation was not accurately or adequately assessed by the auditors. As the Facility unfolds its monitoring systems, staff that are assigned monitoring duties will need to be trained and complete inter-rater reliability assessments. ABSSLC's Supplemental POI indicated that the inter-rater reliability process would begin pending the modification of the monitoring tools by 10/1/10. However, instructions for the tools must be developed and implemented before establishing inter-rater reliability. In addition, departments will need to ensure that staff who are assigned monitoring duties are competent in the areas that they are monitoring. This is essential to ensure the Facility's data accurately reflects the quality of care being provided, and to allow quick identification of problematic trends and implementation of timely plans of correction. In addition, the data generated from the monitoring tools need to be regularly reviewed, addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems. Although the audits reviewed did not accurately identify compliance, there were a number of comments on the audits that indicated that the auditors were identifying	

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		some problematic issues. Some of these issues included: ▪ Lack of documentation that an RN or LVN minimally assessed an individual with a serious acute illnesses or injuries at least daily for the first 72 hours; ▪ Lack of communication and instruction provided to the home staff relating to individuals with a serious acute illnesses or injuries; ▪ Care Plans developed at the Infirmary that were not individualized after return from the hospital; ▪ Quarterly Nursing Assessments lacked necessary information regarding hospitalizations and serious medical issues; ▪ Lack of implementation of Acute Care Plans; ▪ Lack of timely follow-up addressing acute care plans; ▪ Lack of documentation when physician was notified; ▪ Lack of documentation of admission notes for individuals admitted to the Infirmary; ▪ Blanks on Bowel movement records; ▪ Weights not consistently recorded; ▪ Legibility of signatures and notes; and ▪ MOSES or DISCUS not found in the records On 5/1/10, the Facility had implemented a Corrective Action Plan addressing legibility of nurses' signatures for the nursing entries in the medical records that included having the nurses print their name and title next to their signatures. The Nurses' Meeting minutes and meeting rosters dated 3/30/10, 4/1/10, 4/20/10, and 4/22/10 verified that the nursing staff was made aware of the corrective action. However, the minutes also indicated that nurses could purchase stamps with their names in place of printing them. While either action is appropriate, having one consistent method for addressing legible signatures would be best. Whatever system is decided upon, it needs to be added to the appropriate policies, procedures, and/or protocols. From interviews with the CNE, QE Nurse, and nursing staff reviewing medical records with the Monitoring Team while on site, the commitment to understanding, learning, and implementing monitoring systems to identify strengths and weaknesses in nursing practices was clearly evident. ABSSLC's Nursing Department needs to continue to focus their efforts on the implementation of monitoring systems that generate accurate clinical data focused on the quality of nursing services and documentation, and not just the completion of the required documentation. In addition, the Nursing Department has to ensure that all nurses conducting monitoring activities are clinically competent, and are critically auditing their assigned areas to provide data that accurately reflects the quality of the nursing care being provided. This is crucial to the timely identification of problematic trends, so that timely plans of correction can be implemented. Once the QE systems are in place, these data need to be integrated into the Facility's Quality	

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		Management and Risk Management systems. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> The Nurse Manager Monitoring tools from the Nursing Department and QE data indicated that audits were conducted for individuals who experienced an acute illness and/or hospitalizations. However, since the baseline review, there was no improvement found in the quality of the nursing documentation in the medical records for this population. The CNE acknowledged that the monitoring conducted regarding individuals who experienced acute illness and hospitalizations had not yet produced any measurable changes regarding clinical outcomes. A review of 10 individuals' medical records (Individual #65, Individual #289, Individual #403, Individual #26, Individual #331, Individual #468, Individual #361, Individual #23, Individual #93, and Individual #90), who had been transferred to a community hospital, emergency room, or the Infirmary found that there continued to be significant problems regarding the nurses' documentation in the following areas consistent with the baseline findings: ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ Significant gaps in nursing documentation when nurses' notes stated "will monitor;" ▪ The type of temperature taken not consistently documented; ▪ Discrepancies in bowel movement data found in the nurses' notes; ▪ A lack of follow-up from issues noted in previous nurses' progress notes; ▪ A lack of specific description, size, and location of bruises or rashes; ▪ Administration and follow-up for PRNs (as needed medications) not documented; ▪ Inadequate assessments and follow-up addressing pain; ▪ A lack of mental status assessments documented during status changes; ▪ A lack of adequate descriptions of the site of injuries; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ A lack of assessment of bowel sounds and abdomen for individuals with constipation; ▪ Physician/Practitioner not timely notified of change in status due to nurses' inadequate follow-up; ▪ No documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Nurses writing progress notes that lacked adequate objective data; ▪ The lack of specific descriptions of the individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals; ▪ Lack of analysis of contributing problematic issues affecting change of status; ▪ Inappropriate abbreviations;	

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		▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to and from the Infirmary; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room; ▪ No documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the symptoms that precipitated the transfer; ▪ Dates and times not consistently documented for progress notes; ▪ Inconsistent use of format for progress notes [Description, Assessment, and Plan (DAP), Data, Action, Response, and Treatment (DART)]; ▪ Lack of an adequate updated Nursing Care Plan to reflect changes in status and new interventions; and ▪ Many nursing progress notes and signatures were illegible. Similar to the findings from the baseline review, there were a number of significant problematic issues found regarding complete and adequate nursing documentation and assessments of symptoms for acute changes in status for individuals. Also as found during the baseline review, the documentation provided by the hospital liaison nurse for individuals who were hospitalized was consistently exceptional. As an example of some of the problems noted: ▪ In the case of Individual #90, there was evidence in the documentation that her status was changing at least two weeks before she was sent to the hospital. A nursing note indicated that she had "abnormal" lung sounds, however, there was no specific information provided that included what the nurse heard that was abnormal and where it was heard; right side, left side, bilaterally, upper lobes or lower lobes. Consequently, there was no available baseline information for comparison. There was no follow-up documentation found assessing her lung sounds until she was sent to the hospital five days later. In addition, the notes indicated that she had not had a bowel movement, and was given medication for this. However, there was no assessment documented prior to the medication administration of her bowel sounds or abdomen. In addition, she received three more doses of medication for constipation without an assessment, even though one of the nurses' notes indicated that she had a bowel movement as a result of one of her prn medications for constipation. In addition, a subsequent nurse's note indicated discrepancies in the number and size of bowel movements she	

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		had during that week. There were large gaps in nursing documentation even though the notes stated that she would be "monitored." The medical record lacked adequate nursing assessments prior to her transfer to the hospital, as well as upon her return. She was diagnosed with pneumonia while hospitalized, and was not found to have a bowel obstruction. The physician's note indicated that she had vomited shortly after her return to the Facility from the hospital. However, no assessment of her status including lungs sounds was documented. In fact, the episode of vomiting was not found documented in the nurses' progress notes. In addition, there was no indication from the documentation that she was seen or referred to the PNM team for assessment. While on site, two individuals were reviewed with four Case Manager Nurses who had been auditing this area. Initially, the nurses reported that the notes were appropriate and complete. However, when questioned regarding the quality of the documentation and specific components that were missing from the notes, the nurses began to critically audit the notes for clinical quality. To generate accurate data, it is recommended that the auditing staff first read the "story" included in the progress notes from the start of the change of status to the individuals' return to their home unit, and then score the tools. This method would help to ensure recognition of the quality issues related to clinical care and the completeness and appropriateness of assessments, rather than just the completion of notes. Initiating auditing for individuals who have required hospitalizations, ER visits, and admissions to the Infirmary was an appropriate decision by the Nursing Department due to the significant problematic clinical issues found during the baseline and current reviews. By the next review, the department should have generated data for a number of months, and have developed and implemented plans of correction addressing a number of the problematic issues related to acute changes of status. As noted from the baseline review, ABSSLC had a policy addressing "Management of Acute Illness/Serious Injury F-08, ABSSLC Nursing Services Revised October 29, 2009." However, there were not specific instructions included that defined the essentials components of the documentation of assessments, including the name of the physician/practitioner who was notified and timeframes for initiation of an Acute Care Plan (ACP). The Facility's Supplemental POI only addressed the revision of the Nursing Comprehensive Assessment regarding the need to revise and/or develop Nursing policies, procedures, and protocols. However, the CNE reported that the State Office had approved the use of the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing policies, protocols and care plans. At the time of the review, the Facility did not have a definitive plan for when	

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		training would be conducted for new protocols and/or when implementation would occur. Based on the number of medically compromised individuals who had been admitted to the hospital, seen in the emergency rooms, admitted to the Infirmary, and the significant problematic issues found from the baseline and current reviews of acute status changes, this area should be considered a priority for implementation of nursing protocol(s). Although not a requirement in the SA, it would be beneficial to the Nursing Department to modify the State's policy addressing Nursing Peer Review from an investigational process to an educational process. As defined by the American Nurses Association (ANA) in 1988, peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Again, although not a requirement of the Settlement Agreement, the introductory section of the HCG highlights the value of nursing peer review. The Nursing Department is encouraged to utilize this process for regularly reviewing cases focused on the identification of strengths and weaknesses of the Facility's nursing practices, that includes a critical analyses of nursing practices, identification of problematic trends with plans of correction generated for problematic areas found, and continual monitoring for improved clinical outcomes. These activities will certainly contribute to the Facility's movement toward compliance with Section M of the SA, as well as with the Facility's efforts with regard to self-assessment. <u>Availability of Pertinent Medical Records</u> At the time of the review, based on information provided by Records Coordinator at the entrance meeting, the Facility had just completed the process of transitioning the medical records to a unified record. In reviewing records onsite, it was noted that significantly fewer documents had to be obtained from the units compared to the baseline review. There were some Nursing Quarterly Assessments and Nursing Care Plans that were not found in the records, and the units had to locate them. However, all progress notes were found to be available in the medical records from the sample drawn for this review. The Facility needs to continue to ensure that documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. The Facility reported that five charts were to be audited each month to ensure completeness. At the time of the review, the Records Coordinator reported that monitoring tools and procedures addressing this issue had been finalized and the	

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		monitoring of charts recently had begun. As this process continues, although the Settlement Agreement only requires five charts to be audited each month, consideration should be given to increasing the sample size with the goal of auditing 20 percent of the medical records each month to be able to have confidence that the findings of the audits can be applied to all of the medical charts. Although not related to compliance, it would be a beneficial practice to ensure the medical records are being properly maintained. <u>Infection Control</u> The Facility continued to have two registered nurses with various infection control experience. The Director of Infection Control (IC) had been in the position for over two years, and the Infection Control Manager had been in the position for over five years. There were no other clerical or clinical employees added to the department. The Facility's Supplemental POI indicated that it felt the two current IC positions were adequate. Consistent with the findings from the baseline review, ABSSLC's Infection Control (IC) Department continued to track the basic areas regarding the surveillance of MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; current immunizations; current vaccines; and antibiotic use. However, an interview with the Infection Control Director validated that there continued to be no formalized system in place to ensure the reliability of the Facility's IC data. The IC staff reported that they did not consistently receive information from the units regarding infections, so they did compare lab work, physician orders, the Drug Antibody Utilization report from the pharmacy, and Medication Administration Records to ensure that they aware of individuals with infectious issues. It was positive that some of these steps were being taken, but they were not formalized procedures that were required by policy to be completing according to a set schedule. Although the Facility had written procedures describing the databases, the procedures were not specific regarding how these systems were used to ensure data reliability, or how data was being tracked regarding discrepancies between the systems compared. Without ensuring that the IC data are reliable, the Facility cannot timely and accurately identify where training on appropriate IC practices are needed, or identify IC trends and where corrective interventions may be needed. Based on ABSSLC's POI, the Facility reported that they were in substantial compliance with all items except one regarding having a system to assess and document clinical risk indicators for infections. However, without a formal system in place to determine the reliability of the infection control data, neither the Facility nor the Monitoring Team can confirm the validity of this information to make a finding of substantial compliance. The IC Department developed a Procedure for the Communicable Disease Track, dated 8/4/2010, which listed the systems from which the department collects data regarding	

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		infectious issues. Although this procedure is a promising start to identifying ways the department could ensure reliability of the IC data, it lacked important specific information such as when data would be collected from each system, how discrepancies between the systems would be tracked, and where unit reporting fell into the data collection system. In addition, there was no indication regarding how system discrepancies were to be addressed. Due to the clinical relevance and ramifications, data reliability for infection control is essential. Without ensuring that the IC data is reliable, the Facility cannot accurately identify its trends, problematic changes in trends requiring timely corrective interventions, ensuring that treatments and treatment plans are clinically sound, ensuring that timely and appropriate training is being provided, or initiating proactive interventions from analyses of past data trends. Also, the Facility's POI indicated substantial compliance with a number of items regarding compliance with the overall HCG for Infection Control. However, the Facility provided no data to support compliance with these items. In fact, the Director of IC reported that at the time of the review, only three individuals had been reviewed for immunization status and there had not yet been a schedule developed regarding when the rest of the individuals were going to be reviewed. There was documentation supporting that the department was reviewing forms for the documentation of immunizations and that a computer database was being developed to track immunizations. A schedule addressing these issues should be developed to ensure individuals are appropriately prioritized, and that no one is overlooked. There was no question that the department was committed to moving forward in addressing the requirements of the SA. However, demonstrating substantial compliance requires having supporting data from an adequate sample size generated from a monitoring system. Based on interviews and chart review, and the findings discussed throughout this Section, the Facility was not in substantial compliance. The Facility's Supplemental POI indicated that for all items addressing infection control issues a State Office policy was required and that "Facility action would begin after receipt of new/amended policy and direction from the State." However, there were no assigned target dates included in the Supplemental POI. A review of the Facility's Infection Control Manual, dated 7/14/10, indicated that it was reviewed/revised or had additions. It was unclear as to what specific revisions to the Manual were made since no area was found highlighted designating a change. In addition, there was no indication that revisions were made to reflect current standards of practices and requirements outlined in the SA and HCG. Delaying the implementation of Infection Control systems indefinitely compromises the clinical care of the individuals, and places both individuals and staff at risk regarding infectious and communicable diseases. Consistent with the baseline review, the Director of the Infection Control Department	

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		reported that the documentation of the activities of the IC Department was contained in both the IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility used the IC Committee to address issues that pertained mainly to the direct support professionals, and the Pharmacy and Therapeutics Committee was used to address other clinical IC issues such as antibiotic use. Review of the Pharmacy and Therapeutic Committee meeting minutes, dated 4/30/10, found that that it included a discussion regarding a significant increase in urinary tract infections due to E. coli, and related issues such as the possible need for follow-up urinalyses, contaminated samples, adequate hydration, and use of a cranberry extract product. Although the minutes indicated that IC staff had provided in-services to staff regarding appropriate hygiene care, the minutes did not include an analysis of which buildings/units were involved to determine if the individuals affected were able to provide self-care or were dependent on staff for hygiene care. Since the bacteria E. coli originates from fecal material, identifying the affected population would be needed to guide the corrective action plan. From review of the IC Committee Meeting minutes for 4/25/10 and 7/8/10, the structure and format of the minutes were modified to include areas designated for the agenda topic, facts, discussion, and responsible party and status. These changes were positive in that the minutes captured more of the discussion than the previous format. However, there was still significant missing information that rendered the minutes incomplete. For example, the minutes indicated that for the months of December 2009, January and February 2010, there were 27, 25, and 24 urinary tract infections, respectively. The discussion noted that there were patterns of cross contamination in bathing and changing areas in some homes, and staff was immediately in-service. There was no analysis of which homes had the individuals with the UTIs and at which homes cross contamination was found. In addition, it was not clear what constituted the cross contamination. There was no date included in the minutes regarding when the in-service was provided, or if additional in-services were going to be conducted for staff on other shifts. The discussion included that the infection control monitoring would continue of the affected homes. However, there was no indication as to what type of monitoring was to be conducted, how often it would occur, who was assigned to do it, and who would be reviewing the monitoring data. In addition, the Infection Control meeting minutes indicated that Home 6450 had been on restriction due to upper respiratory infections for 10 individuals. The discussion section noted that there was inadequate staffing at this home to properly separate individuals with illness from healthy individuals. However, there was no analysis of how this affected the spread of the infections, and what corrective actions were taken to prevent this from reoccurring. Also, from interviews with the Director of Infection Control, the department appeared to be involved in a number of activities and training	

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		that was not reflected in the minutes of the IC Committee meetings. In addition, a review of Nursing Care Plans found that there had been five individuals from building 6450 that had pin worms in May 2010. However, there was no analysis of this found in the IC minutes reviewed. Clearly, this situation coupled with the outbreak of respiratory infections indicated that proper infection control measures were not being followed in this home. However, there was no analysis conducted and documented or corrective actions implemented. Also, a total of seven homes (6400, 6370, 6360, 6460, 6750, 6510, and 6450) were placed on restrictions due upper respiratory illness, gastrointestinal illness, or pinworms from March through May 2010. Although the minutes of the IC Committee meeting listed the actions that were taken once the infections were identified, there was no analysis of these situations found in any of the documentation reviewed. The Infection Control Committee and Pharmacy and Therapeutics meeting minutes should include a comprehensive analysis that identifies trends in the IC data, describes inquires into problematic trends, corrective actions addressing any problematic trends, the process for monitoring outcomes in relation to the activities, and the interventions of the Infection Control Department in conjunction with the practices on the units. Since the baseline review, the department wrote a report regarding ABSSLC H1N1 Influenza 2009 After Action Report regarding the three H1N1 outbreaks that occurred at the Facility. A review of the report found it to be a candid analysis of the Facility's response to the outbreaks. The report listed a number of things that went well and a number of things that went poorly. Some of the following issues were identified: ▪ Staff not reporting their illness and continuing to work; ▪ New staff afraid to take off sick time with no time accrued; ▪ Staff refusing to wear masks when instructed to because mask were hot and uncomfortable; ▪ Difficulty tracking employees who had the flu and returning to their work areas without notifying Infection Control; ▪ Confusion regarding what masks to use with H1N1; and ▪ Confusion ordering the H1N1 vaccines. The next step should be developing a plan of correction for those issues that were problematic. In addition, conducting a root cause analysis on events such as outbreaks or post exposures would be extremely valuable in providing direction in conducting a comprehensive analysis of the events and identifying systematic issues that contributed to both positive and negative outcomes. As noted from the baseline review, the IC Department developed a number of graphs regarding the Facility's surveillance data that were included in the Infectious Disease	

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		Status documents. However, there continued to be no documentation found that included any analyses of the meaning of the data related to trends, clinical practice and outcome issues. Consequently, the department's data only represented raw numbers, rather than clinical outcome indicators for the Facility's infection control practices. While the Monitoring Team was on-site, it was found that a post exposure (exposure to another person's blood or body fluids) incident involving a number of staff and an individual with HIV had occurred in July 2010. Based on interviews with the IC staff, the residential staff involved had been seen and counseled by the Medical Director and the IC staff, and the individual was transferred to a mental health facility shortly after the incident. When asked about any other additional activities the IC Department conducted related to this incident, the Infection Control Director reported that she had sent an email to all staff after the incident regarding procedures for post exposure injuries, however, the IC staff did not go to the residence and provide any information regarding post-exposure issues. For such a significant event, it would stand to reason that the residential staff would have concerns, fears, and questions regarding health risks. In fact, during the review some of the residential staff shared their concerns with members of the Monitoring Team. When asked why the IC staff did not meet with staff face-to face, the IC staff reported that they were under the assumption that they could not discuss any individual-specific issues with staff regarding HIV. Consequently, the residential staff working with individuals with HIV at ABSSLC had had no additional training about the disease itself or other health related issues associated with the disease specific to the individual for whom they were caring. During the on-site review, a call was initiated to the State's Attorney (DADS) who researched the issues, and stated that informing staff responsible for the care of an individual of the health needs and treatment plans for an individual with HIV was not a breach of confidentiality, and did not violate privacy laws and regulations. Although this appeared to clarify a long-standing question at the Facility, it was unfortunate that actions had not been taken sooner to obtain clarification. This situation clearly indicated that formal systems and communication lines needed to be established between the units, the Infection Control Department, Facility Administration, and the State Office, and written into policies and procedures. A review of 49 Infection Control Monitoring Tools addressing the environment from 2/10 through 6/10 found that the form itself had been modified somewhat in June 2010, but still was very basic. Previously, the tool consisted of 29 items that were mainly focused on environmental issues. It was modified minimally to contain only 23 items. Although a number of issues were found and extensively documented on the Corrective Actions section, there was no indication that all the problems identified were actually tracked to resolution, or that there was a comprehensive analysis of overall findings, identifying trends that led to any type of proactive interventions being implemented. In addition, any findings from these environmental audits were not included in the	

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		Infection Control Committee meeting minutes. The following were examples of issues that required follow-up: ▪ An Infection Control Monitoring tool, dated 6/25/10, noted that the medication room refrigerator and freezer was dirty with strands of back hair adhered to the refrigerator. In addition, the tool indicated that the freezer needed to be defrosted. The response from the Unit Supervisor was: "I will correct items." However, there was no date indicated when the issues were addressed. ▪ An Infection Control Monitoring tool, dated 2/3/10, noted that the Infection Control Nurse discussed the increased cases of ringworm with the RN Case Manger, and recommended training be conducted with staff. There was no indication on the Correction Action Plan that the training was actually conducted. Consistent with the baseline findings, there were no IC formal audits being conducted to ensure that appropriate treatment practices were being implemented regarding infection control issues. For example, there was no formal monitoring system in place to ensure that individuals with MRSA were audited regarding treatment with the appropriate antibiotic in alignment with the culture and sensitivity results, or individuals with Hepatitis C were screened for their immunization status for Hepatitis A and B, and, if needed, had timely received them. In addition, the Facility had not yet begun to address systems regarding individuals who refused treatments, such as immunizations or TSTs, to ensure that that their treatment teams were addressing the refusals and implementing interventions. The Director of Infection Control reported that they had begun reviewing Nursing Care Plans and treatment practices, but were not actually auditing the records with a monitoring tool to collect data. The Infection Control Department was having the unit nurse fax the Nursing Care Plan to the department and any recommendations made by IC were emailed back to the Unit nurse. After modifications were made, the IC Department conducted a final review of the Care Plan. A number of emails were reviewed verifying that IC had begun to review the Care Plans, and had made appropriate recommendations for revisions. The Infection Control Director reported that she found the Nursing Care Plans she reviewed were adequate. However, as discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 33 Nursing Care Plans reviewed by the Monitoring Team addressing infectious diseases, all were found to be inadequate. A review of the Facility's Infection Control course description for orientation and annual classes demonstrated that hand-washing and Standard Precautions were included in the curriculum and in the post-test. However, from review of the curriculum and the post-test for Infection Control, the post-test did not adequately measure competency	

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		regarding the course content. The Facility needs to modify the post-test so that it is reflective of the infection control information taught to the staff to ensure competency in this area. Consistent with the findings during the baseline review, the lack of adequate Nursing Care Plans addressing infectious diseases warrants additional and on-going competency-based training for the Nursing staff. As noted in the baseline report, the Infection Control Department staff had experience and background in Infection Control. They inherited most of the systems of the department, which clearly had significant deficits. The IC staff had put in a considerable amount of energy into moving forward in attempts to meet the requirements of the SA. Clear direction needs to be provided so that the efforts and actions of the IC Department are not wasted on building systems that are not adequate to produce sustainable compliance. Additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control Department in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Since the baseline review in July 2010, the State Office modified the Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The Supplemental POI indicated that implementation of the modified guidelines and nursing assessment form was to begin 8/1/10. The Chief Nurse Executive reported that competency-based training would be initiated during August 2010. The implementation of the modified Comprehensive Assessment was anticipated to begin 8/1/10, but had not been implemented at the time of the review. At the time of the review, the competency-based training curriculum for the Comprehensive Nursing Assessment had not yet been developed. Building competency in this area is critical. The nursing summary section that was included on the new form should provide a clinical analysis of all the data from previous sections regarding the individual's progress related to their health and behavioral goals. The competency-based training for the Comprehensive Nursing Assessment needs to adequately measure nurses' competency in producing a quality comprehensive nursing assessment. The records of 20 individuals who were seen by psychiatry and/or prescribed psychotropic medications were reviewed, including: Individual #418, Individual #267, Individual #424, Individual #163, Individual #402, Individual #30, Individual #483, Individual #61, Individual #74, Individual #308, Individual #438, Individual #544, Individual #545, Individual #140, Individual #405, Individual #365, Individual #397, Individual #370, Individual #165, and Individual #12. A review of the past two quarterly nursing assessments found that 19 of the individuals (95%) had quarterly nursing assessments that were timely completed. One individual (Individual #308) had two	Noncompliance

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		nursing quarterly assessments completed, however, the second quarterly assessment was completed a month early without explanation. Consistent with the findings during the baseline review, none of the 40 assessments (0%) were adequate, and, in fact, the quality of all 40 of the most recent assessments was extremely poor and required significant improvement. The summary narrative section for all of the 40 quarterly assessments reviewed continued to contain raw data without analysis of the data regarding the individual's health status. There were virtually no comparisons of health or behavioral data between the current and the previous quarters to assess if the individual was doing better or worse regarding their health issues, and/or if there was progress or lack thereof on measurable objectives, services and/or supports that were included in the Nursing Care Plans. For example: ▪ The nursing assessment, dated 3/5/10, for Individual #438 indicated that his weight was 116 pounds and that his desired weight was 135 pounds. It also noted that he had behaviors consisting of hitting himself on the left side of his head, which began following a visit home and had increased this quarter. The assessment noted that he had had multiple interventions to aid in comfort, however, no interventions were listed. In addition, he was noted to have a constipation problem and the assessment stated that the bowel management plan was "semi-effective." There was no specific information found addressing what "semi-effective" meant and/or what was being done to increase the effectiveness of his bowel regimen. In addition, the Gastrointestinal section of the assessment indicated that he experienced nausea, but did not include any other information explaining the frequency or duration or treatments for the nausea. The documentation from the assessment indicated that he had an electrocardiography (EKG) conducted on 1/15/09, over a year ago, and that it was "still not on chart." The medication section of the nursing assessment indicated that the individual received Lortab, a medication for pain, on 2/25/10. However, there was no indication of the cause of the pain or the effectiveness of the mediation in treating the pain. The Health Management and Acute Care Plans that were listed on assessment included potential for impaired skin integrity, and potential for serious injury related to ingesting foreign objects. His nursing quarterly summary stated: *[Individual #438] attends school all day off campus. He has had many health issues this quarter. [Individual #438's] weight is being monitored weekly due to weight loss. His weight is improving. He will take the supplement most of the time. [Individual #438] enjoys sensory gym and his quiet time. All health promotion care plans will continue thru the next quarter. [Individual #438] will continue to be encouraged to try different snacks to promote weight gain and maintain. His weight has increased by 9 lb this quarter. [Individual #438] will be encouraged to try snacks with more calories. [Individual #438] enjoys his*	

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		home visits. All training goals and health promotion care plans will be continued thru the next quarter. We will continue to care for [Individual #438] to the best of our ability, and to meet his needs the best we can provide. All campus consultations visits will be coordinated thru medical records. There was essentially no assessment of this individual's status from last quarter with the exception of his weight change. However, there was no assessment and analysis of what was different this quarter that made a positive impact on him being able to have gained nine pounds. In addition, there was no assessment of his behaviors, nausea, constipation, episode of pain, or care plan goals. ▪ A review of the nursing quarterly assessment, dated 6/2/10, for the same individual, Individual #438, indicated that his weight had dropped to 113 pounds, and that on 3/30/10, he had undergone dental surgery. However, no details regarding what was done during the dental surgery were provided. The assessment also indicated that he was seen by the psychiatrist on 5/4/10, but no summary of that appointment was included in the documentation. The assessment again stated that he had behaviors consisting of hitting himself on the left side of his head, which began following a visit home and had increased this quarter, and that he had had multiple interventions to aid in comfort. Again, no interventions were listed. The documentation from the assessment again indicated that he had a constipation problem and that the bowel management plan was "semi-effective." Also, the assessment indicated that he had an EKG conducted on 1/15/09, over a year ago, and that it was "still not on chart." The medication section of the nursing assessment indicated that the individual received Gusdifenesin, an expectorant that helps to thin mucous and make coughs more productive, on 5/23/10 for "Severe acute respiratory syndrome (SARS)." The Health Management and Acute Care Plans that were listed on the assessment included potential for impaired skin integrity, potential for serious injury related to ingesting foreign objects, and the additions of constipation and imbalanced nutrition. His nursing quarterly summary stated: *"[Individual #438] attends school all day off campus. He has had many health issues this quarter. [Individual #438] weight is being monitored weekly due to weight loss. His weight is improving. His present weight is 114 lbs. He will take the supplement most of the time when offered. [Individual #438] enjoys sensory gym and his quiet time. All health promotion care plans will continue thru the next quarter. [Individual #438] will continue to be encouraged to try different snacks to promote weight gain and maintain. His weight has increased by 9 lb this quarter. [Individual #438] will be encouraged to try snacks with more*	

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		calories. [Individual #438] enjoys his home visits. All training goals and health promotion care plans will be continued thru the next quarter. We will continue to care for [Individual #438] to the best of our ability, and to meet his needs the best we can provide. All campus consultations visits will be coordinated thru medical records." This was virtually the identical summary from the previous quarter. It did not accurately address his weight loss over the preceding quarter, or the specific treatments and responses regarding the episode of SARS documented in the assessment. In addition, it provided no analysis of his care plans, and whether they were having the desired effect, or needed to be modified. An additional review of the records of 25 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed, including: Individual #30, Individual #327, Individual #180, Individual #345, Individual #521, and Individual #139 for Diabetes; Individual #123 for skin integrity; Individual #205 for constipation; Individual #213, Individual #13, Individual #253, Individual #262, Individual #228, Individual #470, and Individual #534 for pain; Individual #76, Individual #154, Individual #303, and Individual #505 for behaviors; Individual #272, Individual #491, and Individual #8, and Individual #108 for gastrointestinal issues; and Individual #226, Individual #106, Individual #229 for urinary tract infections. A review of the past two quarterly nursing assessments found that all (100%) of the individuals had quarterly nursing assessments that were timely completed. Consistent with the findings during the baseline review, none of them (0%) were adequate, and, in fact, the quality of all 50 of the most recent assessments was exceedingly poor. For example: ▪ The nursing summary contained in the quarterly nursing assessment dated 4/8/10, for Individual #30 indicated the following: "[Individual #30] *has been very healthy this past quarter with no infirmary admissions. [Individual #30] was seen by the psychiatrist on 3/8/10, will continue current medication and follow-up routine. She has worked a few days in the work shop and she likes to go there after lunch. [Individual #30] had one injury this quarter resulting in a fracture to her left ankle. Care will be the best of our ability. Acute care plan for pain and fracture remains in place."* Clearly, the individual had not been very healthy that quarter since she sustained a fracture. In addition, the nursing assessment did not provide any specific information regarding how she fractured her ankle, what was done to prevent future injuries/fractures, any changes in her functioning associated with the fracture, or if there was an issues regarding osteopenia or osteoporosis contributing to her risk of fractures. The assessment only briefly mentioned the fracture	

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		▪ The Nursing Quarterly Summary for Individual #534 dated 4/15/10 indicated that she frequently refused medical appointments and had refused to take her PPD. The health Management and Acute Care Plans that were listed on the assessment included; Cardiac (the diagnosis not specified), skin integrity related to injuries, challenging behaviors, GERD, seizures, and constipation. A review of the nursing summary section of the assessment found it to be blank. Most of the Nursing Quarterly Assessments reviewed contained discrepancies in the assessments and/or in the nursing summaries largely because much of the information was cut and pasted from the previous assessments. Most of the comment sections included information dating back to 2009 that had not been updated to reflect the individual's current status. In addition, as in the example above, there were clinical contradictions found in the assessment summaries where there were notations that the individual had good health during the quarter, then farther down in the summary, an illness or injure was noted, such as the fracture was that was superficially mentioned. This indicated that nurses were not reading and/or critically analyzing their own assessments, nor were auditors that were monitoring this area. Also, the records of 10 individuals who were school-aged were reviewed, including: Individual #387, Individual #227, Individual #81, Individual #188, Individual #276, Individual #526, Individual #355, Individual #274, Individual #132, and Individual #156. A review of the past two quarterly nursing assessments found that all (100%) of the individuals had quarterly nursing assessments that were timely completed. Consistent with the above findings, none of the 20 Nursing Quarterly Assessments (0%) were adequate, and all contained the same problematic issues as noted in the above reviews. These significant findings regarding nursing assessments reinforce the importance for the Nursing Department to ensure that it is providing clinically appropriate, competency-based training regarding Comprehensive Nursing Assessments. In addition, as the Facility develops and implements the monitoring process for this area, the Facility needs to ensure that the staff auditing this area are clinically competent in determining compliance ratings addressing the quality of nursing assessments.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health	Since the baseline review, the State Office had decided to use the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plans. The CNE reported that the Facility had obtained these resource books. Based on information from the Presentation Handout, dated 8/2/10, and interviews with the Chief Nurse Executive, it was reported that competency-based training regarding Nursing Care Plans had been initiated in June 2010 and the new care plans were	Noncompliance

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	conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	implemented in July 2010. However, in response to a request for copies of any competency-based training for nursing developed since February 2010, the Facility indicated that the item was not available. Although the minutes of the Nursing Meetings indicated that new care plans were discussed, that does not constitute competency-based training. A clinically sound competency-based training curriculum needs to be developed and implemented to ensure nurses' are appropriately trained and can demonstrate the ability to develop clinically adequate nursing care plans. The records of 20 individuals who were seen by psychiatry and/or prescribed psychotropic medications were reviewed, including: Individual #418, Individual #267, Individual #424, Individual #163, Individual #402, Individual #30, Individual #483, Individual #61, Individual #74, Individual #308, Individual #438, Individual #544, Individual #545, Individual #140, Individual #405, Individual #365, Individual #397, Individual #370, Individual #165, and Individual #12. There were no nursing care plans (0%) found addressing the mental health diagnoses, which should have included interventions related to any behavior plans and/or strategies the individuals had, as well as the psychotropic medications prescribed for the individuals. From the review, only templates of care plans addressing risks of injuries related to challenging behaviors were found. However, these templates contained little to no individualization except the addition of some of the individuals' first names in the plan. Moreover, the interventions listed on the care plans did not address ways to prevent injuries from behaviors, but rather only what to do when an injury occurred. For example: ▪ The Nursing Care Plan for Individual #424 indicated that she would be free from injury related to challenging behavior. However, nowhere in the plan was a description of her challenging behaviors provided, or any indication of if she had a behavior plan in place. The objective stated that "individual will remain free of injury/side effects while taking multiple medications for the same diagnosis." However, the plan did not indicate what medications she was taking, the side effects of those medications to be assessed, who would monitor for (e.g., direct support professionals, and, if so, what symptoms they would be trained to monitor for and report), who would formally assess for side effects (e.g., using the MOSES and DISCUSS), how the side effects would be reported, or the diagnosis for which she was prescribed multiple medications. Without individual-specific information, this care plan was meaningless. In addition, the interventions contained in the care plan were the generic interventions from a template, such as "provide a safe environment," and "notify the physician for any condition changes." No information was provided about what a safe environment consisted of for this individual, or what types of changes needed to be monitored for and by whom. The records of an additional 25 individuals who were identified by the Facility as being	

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		at risk for specific health indicators were reviewed, including: Individual #30, Individual #327, Individual #180, Individual #345, Individual #521, and Individual #139 for Diabetes; Individual #123 for skin integrity; Individual #205 for constipation; Individual #213, Individual #13, Individual #253, Individual #262, Individual #228, Individual #470, and Individual #534 for pain; Individual #76, Individual #154, Individual #303, and Individual #505 for behaviors; Individual #272, Individual #491, and Individual #8, and Individual #108 for gastrointestinal issues; and Individual #226, Individual #106, Individual #229 for urinary tract infections. Consistent with the baseline findings, none of the nursing care plans for the 25 individuals (0%) were adequate. Most of the interventions contained in the plans were descriptions of service provisions, such as "administer medication as ordered," "vital sign monitoring," and "monitor for effectiveness of prescribed medications and treatments." The lack of individual-specific interventions provided little to no direction for caring for individuals who were identified as being at risk, and/or for measuring individuals' progress toward their goals. In addition, consistent with the baseline findings, the interventions contained in the nursing care plans were not geared toward prevention or minimizing the health risks. For example: ▪ A review of Individual #228's nursing care plan for aspiration found that the nursing diagnosis indicated that he was at risk for aspiration related to a history of vomiting. The objective stated "breath sounds will remain clear to auscultation." The interventions listed in the care plan included: o Assess breath sounds/respiratory status as needed; o Diet as ordered; o Keep resident in upright position in wheelchair after meals; and o If acute episodes develop, refer to physician for treatment and document per Nursing Procedure Manual. Again, this was an example of a generic template that provided no direction to staff to minimize a risk for aspiration. The plan hinted at issues regarding vomiting, but did not address this in the interventions. Regarding the breath sounds and respiratory status, the plan did not provide any criteria or high risk activities when the breath sounds and respiratory status should be proactively assessed, where this information was to be documented, who would evaluate the information, and how often it would be reviewed. The interventions were not measurable. For example, the term "upright" was not defined, nor was the length of time the individual should remain upright after meals. These interventions were not adequately integrated with any physical and nutritional supports being provided to the individual. The generic nature of the plan rendered it meaningless in providing direction to staff caring for the individual.	

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		The nursing care plans should reflect what nursing is doing for prevention, health maintenance, and health promotion. The plans also should be integrated with the supports being provided by other disciplines, including, but not limited to medical and dental, physical and nutritional supports, psychiatry and psychology, and, most importantly, direct support professionals. The new Health Care Protocols the Facility is implementing will need to include appropriate goals and significant individualization to become Health Care Plans that meet the requirements set forth in the SA and HCGs. Unfortunately, some of the new nursing care plans found in the records were simply the original templates without modifications to make them individualized. An additional sample of individuals' records was reviewed to determine if individuals with infectious diseases had appropriate care plans to address their needs since the baseline review. Specifically, a review was completed of 33 Individuals diagnosed with a variety of infectious diseases, including: Individual #510, Individual #71, Individual #518, Individual #324, Individual #,378 Individual #257, Individual #150, Individual #364, Individual #284, Individual #152, Individual #229, Individual #7, Individual #26, Individual #531, Individual #362, Individual #439, Individual #322, Individual #10, Individual #411, Individual #545, Individual #119, Individual #134, Individual #435, Individual #337, Individual #234, Individual #324, Individual #281, Individual #12, Individual #126, Individual #186, Individual #385, Individual #208, and Individual #162. Of the 33 Nursing Care Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. A joint review of a Nursing Care Plan for an individual with MRSA was conducted while on site with the IC Director, QE Nurse and CNE. Some of the deficiencies noted included: ▪ The lack of individualization of the Nursing Care Plan template; ▪ The lack of designation in reference to documentation regarding who was to document, how often, where the documentation was to be done, who was to review the documentation, and how often it would be reviewed; ▪ The lack of interventions addressing teaching and education for staff and the individual; ▪ The lack of proactive interventions; and ▪ The lack of documentation demonstrating that interventions were actually being implemented As discussed previously, this area needs significant attention due to the clinical relevance of infectious and communicable disease. Consistent with the baseline findings, there continued to be no system in place that ensured that individuals with infectious diseases were actually being provided the appropriate infection control measures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented.	

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		Nursing Care Plans should be a blueprint for guiding staff in providing the needed care and supports for the individual. It should be a document that nurses review to be able to plan and prioritize the activities they need to complete during their shifts. However, the Nursing Care Plans at ABSSLC had not been utilized in this way, and have become more of a task to complete rather than a clinical guide for care. Based on the Facility's POI and interviews with the CNE, the State Office had decided to continue to use Nursing Care Plans rather than pursue integrated care plans that would incorporate all clinical disciplines' interventions into one treatment plan. However, collaboration with other disciplines regarding care plans needs to occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans as required by Sections G and F of the SA. The commitment demonstrated by the ABSSLC Nursing Department since the baseline review with regard to their efforts in trying to move forward in addressing some of the requirements of the SA was impressive. However, efforts and energy expended that do not result in the expected outcome can be demoralizing to a department. The problematic issues discussed in this section and above with regard to Section M.2 of the SA regarding the discrepancies found between the Facility and the Monitoring Team's determinations of what constitutes sound clinical nursing assessments and nursing care plans underscores the need for strong leadership on the State level and additional nursing expertise at the Facility level to assist the Facility in building a clinically sound foundation from which to build enduring nursing systems.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	As reported previously, the State Office had approved the use of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols, and the Facility would need to develop and/or amend existing policies in alignment with the elements contained in the Manual. At the time of the review, the Facility did not yet have a plan for when training would be conducted for newly developed protocols based on priority, or when the implementation of new protocols would occur. As is discussed in detail above with regard to Section M.2 and M.3 of the SA, at the time of the review, the Facility did not have an adequate assessment process in place, nor did it develop appropriate nursing care plans. As a result, the Facility was failing to address adequately the health care needs of the individuals it served.	Noncompliance
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop	Since the baseline review, ABSSLC continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As noted from the previous review, this tool was scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia,	Noncompliance

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	and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. Since the previous review, the Facility had modified this system. Individuals were no longer given an overall score for risk, but were scored for each of the health indicator categories. These indicators were still being discussed at the HST meeting at which time the physician or practitioner assigned the risk score for each category. Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. At the time of the review, the risk tools being used were not adequate risk assessments. Consistent with the findings during the previous review, the Facility's risk system consisting of the Health Risk Assessment tools and the HST meetings did not result in the appropriate identification of individuals at clinical risk. However, the Facility continued to use an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. From observation of the HST meeting on 8/5/2010, the team spent much of the time struggling with how to rate the individual's risk status. The lack of criteria for defining the risk categories prevented the system from being accurate and consistent. In addition, from observing the HST's process, events such as injuries, hospitalizations, or other acute episodes were reviewed as isolated incidents. Once the event was resolved, the team seemed to automatically lower the risk level even though the health risk continued to exist. The current system appeared to be based on a reactive model in that an individual usually had to experience an acute event in order to have their risk level increased. For example: ▪ Individual # 263 had issues with dehydration, constipation, and urine tract infections. In December 2009, he was hospitalized for a bowel obstruction. His risk for constipation was assigned a low risk because he had not had another incident of an obstruction since December. His health issues had not changed, however, the team viewed him as a lower risk since he had not had another acute event. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk. In addition, there should be criteria for the risk categories for consistency so that the process is less subjective, and less likely to mis-identify risk status. The Risk System is the essential foundation that identifies those individuals who warrant the most clinical intensity, and is the alarm for other systems to be called into action. The misidentification of individuals who are at risk substantiated that the foundation had not been appropriately built, and consequently, other associated systems were rendered nonfunctional. It is crucial that the foundation and infrastructure of the system that accurately identifies individuals' risk status be implemented appropriately and swiftly. Once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and	

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		develop plans to address identified areas of risk. ABSSLC and the State Office recognized that they were not in compliance with this requirement of the SA, which was consistent with the Monitoring Team's findings.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Since the baseline review, the Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube. However, it was unclear if the new form had been implemented since no data was submitted in response to the document request regarding six months of medication observation audits, analysis reports and associated plans of correction prior to the review. In addition, the minutes from the Nursing Meeting, dated July 21 and 22, 2010, indicated that quarterly medication pass observation "was to start." The Facility had appropriately modified the frequency of the medication observations for nurses from annually to quarterly as verified in the Nursing Meeting minutes. However, at the time of the review, the policy regarding medication observations had not been revised to reflect this change in procedure. As this system is developed, the department needs to establish inter-rater reliability among auditors in order to produce reliable data regarding medication observations, particularly because various disciplines will be conducting audits. In addition, a tracking system will need to be developed to ensure that each nurse was observed at least quarterly. By the next review, the Facility should have generated two quarters of data from the new observation tool. At the time of the review, there was no report summarizing the issues found from medication observations that were conducted since the baseline review. From a review of the Nursing Meeting minutes, the Medication Error Committee meetings, and the Pharmacy and Therapeutics minutes, there was no indication that data from medication observation audits were discussed. Since the frequency of the observations has increased, the data need to be analyzed to identify trends and generate plans of correction. The Facility needs to develop a system for aggregating this data so it becomes usable to facilitate corrective actions. When observing medication administration while on site for individuals living at 6500, the following significant issues were identified, most of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Pour liquids at eye level to ensure the correct dosage; ▪ Wash her hands consistently between individuals receiving medication; ▪ Speak to individuals as they were adults and not children; ▪ Assist individuals at their own pace, because she was in a hurry to be done on time; ▪ Flush tubes with 30 cc of water between each medication given;	Noncompliance

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		▪ Use gloves when manipulating tubes; ▪ Tell individuals what she was doing and what medications she was administering; and ▪ Ensure the individual was in the proper positioning prior to medication administration. During the observation, a nurse who had conducted many of the medication administration observation audits accompanied the reviewer. The nurse provided some appropriate prompting and feedback to the staff nurse who was being observed. However, she did not intervene when the nurse being observed was too quickly pouring the medications in an individuals' mouth in a nearly frantic attempt to get all the individuals their medications on time. Based on a conversation with the nurse being observed, she reported that trying to get the medications administered before the individuals had breakfast or left for their activities had been challenging, and if they left before she could give them their medications, she was then out of compliance with the time parameters for medication administration, and the individual would either miss the medication or receive it late. This dilemma for this nurse, as well as for probably many more nurses, is an issue that the Facility needs to address so that medications are administered appropriately and safely to individuals. In addition, while on site, the Monitoring Team discovered that in building 6360 a nurse was counting the narcotics at change of shift with direct support professionals. For a Facility such as ABSSLC that had a full complement of nurses, this practice was not acceptable and should be modified. A review of the medication variances reported by the Facility indicated the following; ▪ January 69 reported variances; ▪ February: 44 reported variances; ▪ March: 123 reported variances; ▪ April: 114 reported variances; and ▪ May: 177 reported variances. A review of the minutes of the Medication Error Committee from March through April 2010 indicated that the Facility was identifying the variances based on the numbers of medications that were left over at the time the medications carts were refilled with another month of medications. The minutes indicated that the Facility had designated these variances as "unknown," since there was no way to determine if individuals had not actually received the medications, or if the pharmacy had provided too many medications resulting in leftovers. The discussion from the minutes indicated that pharmacy was actively involved in the committee, which is necessary for this issue to be	

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		addressed. This issue is further discussed with regard to Section N.8 of the SA. As stated in the baseline report, having a medication variance system would expand the scope of the review of the medication system. The medication error system the Facility currently has in place only reviews errors addressing the wrong patient, wrong time, wrong dose, wrong route, wrong drug, wrong technique, and omitted medications. Categorizing the leftover medications as "unknown" essentially misidentifies the bulk of the medication variances the Facility currently has. There are far more system issues that can contribute to medication variance than a breach of one of the "six rights" for medication administration. In fact, only using these limited indicators as a measure of the Facility variances limits the analysis of the system. This limitation was evident from review of the Medication Error Committee meeting minutes. There was no analysis of the Facility's data found in the minutes. The Facility had graphs representing the variance by various categories such as the shift, unit, and building. However, there was no discussion found addressing this information. In addition, there was no indication that any type of corrective actions were discussed or implemented. However, the participation of the Pharmacy and the Medical Director in the committee is a positive step that should bring additional clinical expertise in reviewing this critical area. Consistent with the baseline findings, the Facility was very weak in the area of analyzing the medication administration and variance system. Overall, a facility of its size and the number of medications given each day, as well as the data collected by the Facility through its medication error system, indicated that there continued to be a significant issue of underreporting of medication variances. The CNE was cognizant of reinforcing to staff that finding and reporting medication variances will not result automatically in punitive measures. Enlisting staff in reporting variances will take time and consistency for them to trust that the information is used to analyze and assess the strengths and weakness of the Facility's medication administration system. The Facility needs to continue its efforts to include to having medication nurses involved in the Medication Error Committee or assessments of the medication administration system.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. ABSSLC should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement.
2. The Facility should continue its efforts to develop the processes necessary for the generating data that can be accurately interpreted, analyzed, and are reflective of the practices being measured. These include:
    a. Developing review tool instructions. The Facility in conjunction with the State Office should develop instructions for each monitoring

tool to ensure that all auditors are using the same documentation and criteria to determine compliance with each item, which will assist in establishing inter-rater reliability;
   b. Providing the total of the population being reviewed (N) and the sample of that population audited (n) to yield an adequate percent sample to indicate the relevance of the compliance scores;
   c. Establishing and reviewing an adequate sample size;
   d. Assessing for quality;
   e. Developing and implementing a procedure for establishing inter-rater reliability at 85% or above;
   f. Ensure that all nurses conducting monitoring activities are clinically competent in the areas they monitor; and
   g. Ensure that audits consist of a critical review of nursing practices.
3. Data generated from the monitoring tools should be regularly analyzed, the results addressed by the appropriate disciplines, and integrated into the Facility's Quality Management and Risk Management systems.
4. To generate accurate data regarding acute illness and urgent care, it is recommended that the auditing staff first read the "story" included in the progress notes from the start of the change of status to the individuals' return to their home unit, and then score the tools. This method would help to ensure recognition of the quality issues related to clinical care and the completeness and appropriateness of assessments, rather than just the completion of notes.
5. The Facility should continue its efforts to ensure that documents are filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
6. The Facility should develop a schedule for training on the newly developed nursing care protocols, based on priority of need, as well as when implementation will occur.
7. Although not required by the SA or HCG, the Facility is encouraged to implement the peer review process in alignment with the American Nurses Association definition that states: peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Such efforts should substantially assist the Facility in meeting other requirement of the SA, as well as meeting the goal of adequate self-assessment.
8. The Infection Control Committee and the Pharmacy and Therapeutics Committee should collaborate to ensure that infection control issues are adequately addressed in each respective committee. In addition, the minutes of both meetings should include a comprehensive analysis of the infection control data including trends identified, inquires into problematic trends, corrective actions addressing any problematic trends, and the process for monitoring outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units.
9. The Facility needs to develop a procedure outlining the specific process to ensure data reliability for infection control, including how discrepancies in the data are reconciled and tracked.
10. The Facility needs to continue to implement the process for reviewing and updating if necessary, individuals' immunizations and develop a schedule addressing when individuals will be reviewed based on priority needs so that no one is overlooked.
11. Due to the implications for both individuals and staff related to having adequate infection control policy and procedures in place and implemented, and given that the Facility appeared to be awaiting guidance from the State, the State should prioritize the development of the Infection Control policy and procedures.
12. The Infection Control Department should consider conducting root cause analyses on events such as outbreaks or post exposures to have a framework and structure for completing a comprehensive analysis and identifying systematic issues that contributed to both positive and negative outcomes.
13. Formal systems and communication lines need to be established between the units, the Infection Control Department, Facility Administration, and the State Office, and written into policies and procedures regarding infectious and communicable diseases, specifically regarding human

immunodeficiency virus.

14. The Facility should modify the post-test regarding the Infection Control training so that it is reflective of the infection control information taught to the staff to ensure competency in this area.
15. The Facility should provide on-going competency-based training to staff related to infection control issues.
16. The Monitoring Team continues to recommend that the State consider securing the services of an expert in the areas of Infection Control and Nursing to provide consultation and onsite assistance to the State and Facilities.
17. The Facility should develop and implement clinically sound competency-based training curricula for Nursing Assessments and Nursing Care Plans ensuring that it adequately measures nurses' competency in producing quality documentation in these areas.
18. The nursing care plans should reflect what nursing is doing for prevention, health maintenance, and health promotion. The Facility needs to ensure that the new Health Care Protocols the Facility is implementing include appropriate goals and significant individualization.
19. As required by Section G and F of the SA, the Nursing Department should collaborate with other disciplines regarding care so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans.
20. The State should provide strong leadership to ensure that nurses are familiar with the criteria and standards regarding nursing assessments and nursing care plans. Additional nursing expertise at the Facility level is needed to assist the Facility in building a clinically sound foundation from which to build adequate nursing systems.
21. Once the Facility has reporting protocols in place, a schedule for training based on priority needs to be developed.
22. As is recommended with regard to Section I of the SA, standardized risk assessments with established reliability and validity should be used by all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.
23. The Facility should revise and/or implement policies/procedures/protocols with regard to medication administration monitoring to:
    a. Reflect changes that have been implemented such as increasing the frequency of medication observations;
    b. Address inter-rater reliability since a number of monitoring systems are being implemented by several disciplines;
    c. Aggregate and analyze the data so it becomes usable to facilitate corrective actions;
    d. Based on review of the data, address issues regarding the medication administration system so that medications are administered appropriately and safely to individuals;
    e. Address the change of shift narcotic count.
24. The Facility should consider using a medication variance system as this would expand the scope of the review of the Facility's medication systems.
25. The Facility should continue its efforts to include having medication nurses involved in the Medication Error Committee, and/or assessments of the medication administration system.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Valproic Acid (any form) Drug Utilization Evaluation, dated April 2010; o Calcium Supplements Drug Utilization Evaluation, dated July 2010; o Proposed Surveillance Study 7/28/10 Valproic Acid (Depakene), Divalproex sodium (Depakote, Depakote ER, Depakote Sprinkles); o Pharmacy and Therapeutics Committee Meeting minutes, dated 1/28/10; o Pharmacy and Therapeutics Committee Meeting minutes, dated 4/30/10; o Pharmacy and Therapeutics Committee Meeting minutes, 7/28/10; o "Interventions" report 5/1/10 through 7/31/10; o Quarterly Drug Regimen Reviews for the following individuals: Individual #289 on 5/25/10, Individual #31 on 6/22/10, Individual #165 on 6/2/10, Individual #363 on 6/9/10, Individual #440 on 6/2/10, Individual #196 on 6/9/10, Individual #304 on 6/9/10, Individual #324 on 6/9/10, Individual #469 on 6/2/10, Individual #188 on 5/19/10, Individual #146 on 5/19/10, Individual #517 on 5/19/10, Individual #300 on 7/16/10, Individual #396 on 7/16/10, Individual #470 on 6/22/10, Individual #191 on 6/22/10, Individual #411 on 5/25/10, Individual #11 on 5/25/10, Individual #532 on 5/25/10, Individual #76 on 6/18/10, Individual #128 on 6/18/10, Individual #529 on 6/18/10, Individual #35 on 6/18/10, Individual #42 on 7/6/10, Individual #228 on 7/6/10, Individual #118 on 7/2/10, Individual #164 on 7/2/10, Individual #13 on 7/2/10, Individual #254 on 7/2/10, Individual #268 on 5/7/10, Individual #417 on 5/7/10, Individual #510 on 5/7/10, Individual #463 on 5/7/10, Individual #78 on 7/12/10, Individual #203 on 7/12/10, Individual #370 on 7/12/10, Individual #388 on 7/12/10, Individual #235 on 7/12/10, Individual #323 on 6/2/10, Individual #284 on 5/12/10, Individual #364 on 5/12/10, Individual #245 on 5/12/10, Individual #199 on 5/7/10, Individual #115 on 7/16/10, and Individual #232 on 7/2/10; o Single Patient Intervention Report for the following individuals: Individual #294 on 7/14/10, Individual #514 on 6/10/10, Individual #25 on 5/25/10, Individual #427 on 5/25/10, Individual #478 on 4/27/10, Individual #247 on 4/26/10, Individual #188 6/21/10, Individual #79 on 6/8/10, Individual #538 on 6/3/10, Individual #411 on 5/26/10, Individual #293 on 5/19/10, Individual #469 on 4/29/10, Individual #347 on 4/27/10, Individual #61 on 4/26/10, Individual #247 on 4/23/10, and Individual #331 on 4/22/10; o Medication Errors Sorted by Error Type for May 2010; o Medication Errors Sorted by Shift for May 2010; o Medication Errors Sorted by Error Node for May 2010; o Medication Errors Sorted by Severity for May 2010;

	○ Medication Errors Sorted by Home for May 2010; ○ Medication Errors Sorted by Unit for May 2010; ○ Medication Errors Sorted by Nurse for May 2010; ○ Medication Errors Sorted by Individual for May 2010; ○ State Supported Living Centers Medication Error Report form; ○ Medication Administration Observation Tool, ABSSLC Nursing, revised 6/23/10; ○ State Supported Living Centers Medication Error Report for the following individuals with date of error discovered: Individual #216 on 6/29/10, Individual #100 on 6/22/10, Individual #485 on 6/22/10, three reports for unknown individual on 6/15/10, Individual #151 on 6/15/10, Individual #287 on 6/15/10, Individual #320 on 6/15/10, two reports for Individual #151 on 6/17/10; ○ Monthly Errors by Type January 2010 to June 2010; ○ Monthly Errors by Category September 2009 to May 2010; ○ [Monthly Errors] Sorted by Node December 2009 to June 2010; ○ [Monthly Errors] Sorted by Severity December 2009 to June 2010; ○ [Monthly Errors] Data Sorted by Shift December 2009 to June 2010; ○ [Monthly] Errors by Unit December 2009 to May 2010; ○ [Errors] Sorted by Home December 2009 to June 2010; ○ Medication Errors Sorted by Individual March 2010 to June 2010; ○ Medication Errors Sorted by Nurse March 2010 to June 2010; ○ Medication Error Committee minutes, December 16, 2009, January 27, 2010, March 3, 2010, March 31, 2010, April 28, 2010, May 26, 2010, July 7, 2010, and July 28, 2010; ○ Facility Reporting of POI data Medications, dated June and July 2010; ○ Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) ratings for the following individuals according to date of review by prescriber: Individual#284 (MOSES 2/8/10, 5/10/10; DISCUS 2/8/10, 5/10/10), Individual #199 (MOSES 4/19/10,7/12/10; DISCUS 4/19/10, 7/12/10), Individual #196 (MOSES 2/1/10, 5/3/10; DISCUS 9/25/08, 5/3/10), Individual #517 (MOSES 4/27/10 12/20/09; DISCUS 1/25/10, 4/27/10), Individual #469 (MOSES 4/13/10, 7/23/10; DISCUS 4/13/10, 7/23/10), Individual #323 (MOSES 4/13/10, 7/23/10; DISCUS 4/13/10, 7/23/10), Individual #76 (MOSES 4/13/10, 6/28/10; DISCUS 4/13/10, 6/28/10), Individual #228 (MOSES 4/13/10, 7/13/10; DISCUS 4/13/10, 7/13/10), Individual #164 (MOSES 6/4/10, 7/14/10; DISCUS 6/4/10, 7/14/10), and Individual #268 (MOSES 4/19/10, 7/12/10; DISCUS 4/19/10, 7/12/10); ○ Medication Adverse Reaction Reports on the following individuals: Individual #180 on 3/31/10, Individual #103 on 3/31/10, Individual #287 on 3/26/10, Individual #499 on 4/8/10, Individual #520 on 1/21/10, Individual #518 on 4/29/10, Individual #54 on 5/6/10, Individual #293 on 5/6/10, Individual #357 on 5/19/10; ○ Restraint (chemical) checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint for the following individuals: Individual #310 on 3/2/10, Individual #43 on 3/9/10, Individual #349 on 3/10/10, Individual #120 on 3/23/10, Individual #304 on 3/24/10, Individual #331 on 3/29/10, Individual #310 on 4/1/10,

	Individual #324 on 4/14/10, Individual #505 on 4/14/10, Individual #324 on 4/15/10, Individual #154 on 5/1/10, Individual #387 on 5/4/10, Individual #505 on 5/20/10, Individual #505 on 5/22/10, Individual #505 on 5/25/10, Individual #79 on 5/25/10, Individual #310 on 5/26/10, Individual #505 on 5/29/10, Individual #430 on 6/9/10, Individual #505 on 6/2/10, Individual #505 on 6/3/10, Individual #505 on 6/4/10, Individual #505 on 6/11/10, Individual #324 on 6/17/10, Individual #505 on 6/18/10, Individual #324 on 6/24/10, and Individual #505 on 6/25/10; o Drug Utilization - High Anticholinergic Activity, from 3/1/10 to 3/31/10; o Drug Utilization - High Anticholinergic Activity, from 7/8/10 to 7/15/10 o Benzodiazepine Medications by Patient, from 6/1/10 to 6/30/10; o Summary of Psychotropic Medications/Cogentin Use – ABSSLC, from 4/1/10 to 7/1/10; o Summary: Psychotropic Medications as of 4/13/10 Baseline Report; o Chemical Restraint Trending 2010: Number of doses given per Quarter 1 through Quarter 4; o Chemical Restraint for Behavior Fiscal Year (FY) 2010; o Chemical Restraint Trending Number of does given per month FY 2008 through FY 2010 o Psychotropic Polypharmacy Review Committee meeting minutes, dated 5/3/10, 6/15/10, and 7/5/10; and o Physician Psychotropic Medication Review for Individual #23 from 5/1/10 to 5/31/10; Individual #188 from 5/16/10 to 6/15/10; Individual #103 from 4/1/10 to 4/30/10, and 5/1/10 to 5/31/10; Individual #30 from 5/1/10 to 5/31/10; and Individual #522 from 4/6/10 to 5/5/10, and 5/6/10-5/31/10 ▪ **Interviews with**: o Leah Robinson, R. Ph., Pharmacy Director; and o Marla Knight, Pharm D, Clinical Pharmacist
	Facility Self-Assessment: According to the Facility POI dated 5/17/10, the Facility's review of pharmacy services and safe medication practices series of action steps found several areas in compliance. These included new medication order reviews (N.1), lab reviews on quarterly drug regimen reviews (QDRRs) (N.2), and MOSES and DISCUS evaluations (N.5). This was not wholly consistent with the Monitoring Team's assessment. As noted below, the Monitoring Team found compliance with N.1, N.6, and N.7, but not with N.5 At the time of the review, the Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Because the POI submitted did not include this information, the Monitoring Team was not able to determine how the Facility had assessed compliance, or account for the discrepancies between the Facility's assessment, and the Monitoring Team's assessment.
	Summary of Monitor's Assessment: With regard to the provision of adequate pharmacy services, and safe medication practices, there had been substantial progress since the last team visit. On review of information submitted, the Pharmacy Department was in substantial compliance in a number of areas,

	including the following sections of the SA: N.1, N.6, and N.7. Section N.3 of the SA continued to be a challenge, because a method to monitor the use of "stat" medications had not been resolved. This may require several department directors to convene to determine the roadblocks, and to create a system in which the clinical pharmacist can be helpful at the time of the need for medication. For Section N.5 of the SA, there were a number of problems remaining to be resolved with regard to the periodic completion of the MOSES and DISCUS evaluations. Medication errors and variance remained a concern. A double check system on all autofills likely would eliminate any variance caused by pharmacy. The pharmacy was delivering a two-week supply of medications to the homes, but given the medication error rate, consideration should be given to sending a smaller supply. The other areas in this section had reached substantial compliance. Primary care practitioners were responding to the QDRR. Adverse Drug Reactions (ADRs) were being reported, and Drug Utilization Evaluations (DUEs) were being completed.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug	The pharmacy had a system in which each prescription of a new medication was reviewed for significant drug interactions with other medications currently being prescribed, side effects, allergies, drug disease states, laboratory testing requirements and dosage considerations. The WORx system and AVATAR system were used to assist in this process. A "Single Patient Intervention Report" for Individual #294 on 7/14/10 was typical of the information provided as part of the quality assurance computer system used by the pharmacy. It included age, sex, allergies, diagnosis, indicated medication, and prescribing practitioner. From 5/1/10 through 7/31/10, there were 36 prescriptions that indicated a concern about the individual's order, and in 35 cases information was submitted to indicate the category of concern. The WORx software allowed the recording of details of any pharmacist intervention. In each of these 35 cases (100%), the prescribing health care provider was contacted, and the results included in the "Intervention" section of the pharmacy computer program. Of these interventions, 21 of the interventions (60%) resulted in a change in order. Of the remaining 14, the physician was given the information, usually a potential drug interaction or the need for increased monitoring, but at the discretion of the physician after discussing with the pharmacist, decided that the information did not rise to the level of concern to change the order. This illustrated the thoroughness of the review of the pharmacy department, and the great value this	Substantial Compliance

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	literature.	brings to the medical department in assisting in quality review of medication orders. A sample of 15 "Single Patient Intervention Report" forms also was reviewed. Of these seven out of 15 (47%) reflected changes to orders based on information the pharmacist provided to the PCP. Those reflecting changes to orders included Individual #478 on 4/27/10, Individual #247 on 4/26/10, Individual #188 on 6/21/10, Individual #79 on 6/8/10, Individual #538 on 6/3/10, Individual #411 on 5/26/10, and Individual #293 on 5/19/10. The remaining eight reports (53%) reflected communication with concern, but this did not rise to the level of concern to change the orders. These included Individual #469 on 4/29/10, Individual #347 on 4/27/10, Individual #61 on 4/26/10, Individual #247 on 4/23/10, Individual #331 on 4/22/10, Individual #514 on 6/10/10, Individual #25 on 5/25/10, and Individual #427 on 5/25/10.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A Quarterly Drug Regimen Review (QDRR) was completed on every individual residing at ABSSLC for the latest quarter. The QDRRs began the first quarter of 2010 with the addition of the clinical pharmacist to the pharmacy department. For the second quarter, about 480 QDRRs were completed. This averaged about eight homes per month with an average of 25 individuals per home. All information was reviewed manually. There was no software currently available to assist the clinical pharmacist, although there are several available, such as Rxpertise. This software allows the data to be graphed and recorded and allows for comparison of data sets. It is recommended that such a software program be purchased for the clinical pharmacist, so that the data collection can be further sorted and analyzed to provide meaningful information by which the medical and pharmacy departments can develop plans, including goals for improvement. It also would improve the laborious task of providing 480 QDRRs each quarter in a more efficient way, and utilize the time and expertise of the clinical pharmacist optimally. Each Quarterly Drug Regimen Review included a complete listing of lab tests required for the various medication protocols as well as listing of current labs completed. Abnormal results and non-therapeutic medication levels seemed to have been identified, and were referred to in the recommendations section. However, there was little information on the QDRR with regard to the actual levels, especially drug levels, to indicate if they were in the therapeutic range. The physicians were complimentary of the scope and details included in the information provided for review, as well as the recommendations made. The form was revised to include a line on which the physicians sign as to whether they accept the recommendations or not. All QDRRs go to the PCPs for review. The form, when completed, was placed in the record. The following 21 QDRRs were reviewed to determine completeness of lab review:	Noncompliance

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		Individual #228 on 7/6/10, Individual #118 on 7/2/10, Individual #164 on 7/2/10, Individual #13 on 7/2/10, Individual #254 on 7/2/10, Individual #268 on 5/7/10, Individual #417 on 5/7/10, Individual #510 on 5/7/10, Individual #463 on 5/7/10, Individual #78 on 7/12/10, Individual #203 on 7/12/10, Individual #370 on 7/12/10, Individual #388 on 7/12/10, Individual #235 on 7/12/10, Individual #323 on 6/2/10, Individual #284 on 5/12/10, Individual #364 on 5/12/10, Individual #245 on 5/12/10, Individual #199 on 5/7/10, Individual #115 on 7/16/10, and Individual #232 on 7/2/10. An additional 24 QDRRs, which are listed below with regard to Section N.3 of the SA, were reviewed for the same information. All 100% (45/45) of the QDRRs addressed lab results. However, it was not clear from the documentation whether the clinical pharmacist identified abnormal, sub-therapeutic or toxic drug levels, and it is recommended that drug levels be marked as normal range, or low or high, if beyond the range to clarify the purpose of the QDRR in reference to lab reviews.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Monitoring the use of benzodiazepines, anticholinergics, polypharmacy (with additional review of diagnosis to justify use of medication and the risks of polypharmacy), as well as monitoring of metabolic and endocrine risks associated with antipsychotic medication was included in the campus-wide reviews of the Quarterly Drug Regimen Review. The QDRRs for twenty-four individuals were reviewed to determine whether the pharmacy practice at ABSSLC included these categories. QDRRs were reviewed for the following individuals: Individual #289 on 5/25/10, Individual #31 on 6/22/10, Individual #165 on 6/2/10, Individual #363 on 6/9/10, Individual #440 on 6/2/10, Individual #196 on 6/9/10, Individual #304 on 6/9/10, Individual #324 on 6/9/10, Individual #469 on 6/2/10, Individual #188 on 5/19/10, Individual #146 on 5/19/10, Individual #517 on 5/19/10, Individual #300 on 7/16/10, Individual #396 on 7/16/10, Individual #470 on 6/22/10, Individual #191 on 6/22/10, Individual #411 on 5/25/10, Individual #11 on 5/25/10, Individual #532 on 5/25/10, Individual #76 on 6/18/10, Individual #128 on 6/18/10, Individual #529 on 6/18/10, Individual #35 on 6/18/10, and Individual #42 on 7/6/10. For benzodiazepines, 15 were not prescribed this category of medication. Of the remaining nine reviews, nine out of nine reviews (100%) monitored the use of this category of medication. Focus was on ensuring an appropriate Diagnostic and Statistical Manual for of Mental Disorders (DSM) diagnosis for the use of the benzodiazepine. Although the form indicated review to ensure the "patient is free of potential interactions," as well as "monitoring and evaluation of drug effectiveness, side effects, toxicity, or adverse effects," it did not define individual specific "associated risks" nor the monitoring, if any, recommended for this. For anticholinergics, seven of the 24 were not prescribed this category of medication. For the other 17 QDRRs, 17 out of 17 (100%) reviewed the side effect profile and	Noncompliance

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		applicable drug-drug interactions. Six of the reviews indicated no polypharmacy. Eighteen of eighteen reviews were 100% compliant in reviewing the polypharmacy in the individual's drug regimen. Clinical justification was implied by the pharmacist's comments and recommendations, especially when a diagnosis was researched and could not be found. Additionally, there was reference to the monthly psychiatry clinic notes. However, as required by the SA, it is important to clearly identify that for polypharmacy, each medication has clinical justification [i.e., matched to a diagnosis from the (DSM) or the International Statistical Classification of Diseases and Related Health Problems]. It would appear the research is being accomplished, but not clearly recorded. The following provide some examples: ▪ For Individual #165, the DRR dated 6/2/10 indicated the pharmacist could not find a diagnosis to justify the use of Tranxene, Paxil, and Risperdal. ▪ In other cases, the DRR referred to psychology and psychiatry notes, but did not clearly identify the diagnosis for the medications in the document. For Individual #517, who was on many psychotropic medications, it was not clear from the DRR dated 5/19/10 what the diagnosis was for the use of Trazodone. There were also other non-psychiatric medications without a diagnosis. It is important to determine the diagnostic justification for all medications used. Referencing other psychology and psychiatry notes provides a reference, but these notes are not readily available when reviewing the Drug Regimen Review. In the chart there were various places the diagnosis could be found, but the clinical pharmacist, as part of the monitoring system, would be expected to bring this information together in a concise manner in this document to ensure clinical justification of all medications. In most instances, the pharmacist was aware of the diagnosis for each individual medication, hence, the research was done, but it was not clearly reflected in the DRR document. All 24 QDRRs (100%) included metabolic and endocrine relevant lab data. Of these, six cases (25%) documented noncompliance with timely lab reports. These issues were then discussed at the Pharmacy and Therapeutics Committee Meeting. The Pharmacy and Therapeutics Committee was composed of the Pharmacy Director, Clinical Pharmacist, Chief Nurse Executive, Medical Director, Chief Psychologist or designee, Primary Care Practitioners, and several other RNs. It did not include representation from the Dental Department, or from psychiatry. It is recommended that the Dental Director be invited to participate as a member, and that psychiatry be a consultant to the committee, but not a voting member. Additionally, psychiatry may be able to join the committee meeting by phone, if technology and timing allow. At the 4/30/10 meeting, it was decided that review of anticholinergic drug usage would be discussed at each meeting. The clinical pharmacist indicated that anticholinergic burden	

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		was discussed on every QDRR. The next step was for each PCP to review Cogentin use, to discuss anticholinergic burden with the psychiatry consultants at the polypharmacy psychiatry reviews, and obtain baseline data of Cogentin use with diagnosis. At the 7/28/10 Pharmacy and Therapeutics Committee Meeting, it was documented that "current lists of individuals on high anticholinergic activity drugs sorted by home were distributed to each practitioner." Use of Cogentin on 4/1/10 was compared to use on 7/1/10. The number of individuals on Cogentin had decreased from 124 to 106, and of the remaining 106, 14 had had dosages decreased. At the 4/30/10 meeting it also was reported that the baseline psychotropic drug use was 748 prescriptions, with a goal to reduce this number. At the 7/28/10 Pharmacy and Therapeutics Committee Meeting, an update on progress on reduction of use of psychotropic medication was discussed. From 4/1/10 to 7/1/10, there was a decrease in psychotropic drug use from 748 to 698. The Psychotropic Polypharmacy Review Committee was composed of primary care practitioners, psychiatrists, pharmacist, nurses, and home support staff, and provided a collaborative effort to reduce psychotropic medication use. It targeted specific individuals on multiple medications who would benefit from review by a wide range of disciplines in an attempt to improve quality of life, yet reduce medication use and drug-interactions. It is recommended that the performance plans be monitored to ensure completion of the steps agreed upon and measurement of the progress/outcome, in order to determine the impact of the committee. The Physician Psychotropic Medication Review also targeted those on psychotropic medication. Individuals reviewed included Individual #23 from 5/1/10 to 5/31/10; Individual #188 from 5/16/10 to 6/15/10, Individual #103 from 4/1/10 to 4/30/10, and 5/1/10 to 5/31/10; Individual #30 from 5/1/10 to 5/31/10, and Individual #522 from 4/6/10 to 5/5/10, and 5/6/10 to 5/31/10. It was a brief review, conducted weekly to monthly, and included reviews of medications, dosages and schedule; target behaviors; side effects; overall impression of clinical effect; and action steps. All areas were completed in each of the reviews. That the action steps often had discrete changes in orders or information as to maintaining the current regimen indicated this working group was effective and efficient. The reviews were attended by a variety of staff, including a psychiatric assistant, pharmacist, RN, and QMRP. The use of "stat" chemical restraints also was reviewed. In November of 2009, the restraint policy was changed to require debriefing and specific monitoring after each chemical restraint. This had led to decreased use of medication as staff were more fully informed of side effects. The numbers of chemical restraints had declined since November 2009. The following data regarding numbers of chemical restraint was taken	

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		from the Pharmacy and Therapeutics Committee's Meeting minutes: September 2009 = 32, October 2009 = 27, November 2009 = 36, December 2009 = 9, January 2010 = 9, February 2010 = 15, March 2010 = 6. At the 7/28/10 Pharmacy and Therapeutics Committee Meeting, the minutes documented a consistent decrease in chemical restraint use. Three individuals received nine doses in June 2010. This was attributed to increased monitoring required as well as the need to consult a psychologist prior to medication administration. The "Restraint checklist" and "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" were reviewed for Individual #43 dated 3/9/10, Individual #331 dated 3/29/10, Individual #349 dated 3/10/10, Individual #120 dated 3/23/10, Individual #304 dated 3/24/10, Individual #310 dated 3/2/10, Individual #310 dated 4/1/10, Individual #324 dated 4/14/10, 4/15/10, Individual #505 dated 4/14/10, Individual #154 dated 5/1/10, Individual #387 dated 5/4/10, Individual #505 dated 5/20/10, Individual #505 dated 5/22/10, Individual #505 dated 5/25/10, Individual #79 dated 5/25/10, Individual #310 dated 5/26/10, Individual #505 dated 5/29/10, Individual #430 dated 6/9/10, Individual #505 dated 6/25/10, Individual #505 dated 6/18/10, Individual #505 dated 6/11/10, Individual #505 dated 6/4/10, Individual #505 dated 6/3/10, Individual #505 dated 6/2/10, Individual #324 dated 6/24/10, and Individual #324 dated 6/17/10. None of the 27 (0%) Face-to-Face Assessment forms contained the last page that included an entry space for a pharmacist comment. Consequently, none of the "Face-to-face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" forms had any documentation to suggest a pharmacist had been involved in the review of the "stat" medication or chemical restraint. The clinical pharmacist could assist in providing the most appropriate choice and dosage of medications, and offer alternatives. Also, the clinical pharmacist could append a log of prior chemical restraint use, with time, date, reason, effect, and complications, to assist the PST in developing approaches to minimize use and frequency, as well as dosage strength of chemical restraints. However, the pharmacist was not part of the process at ABSSLC at the time of the review. Compliance was 0%. One individual, Individual #505, had several chemical restraints recorded, suggesting the need for urgent collaboration between the physician, psychologist, and pharmacist. Additionally, "Face-to-face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" forms were not submitted with the "Restraint Checklist" form for Individual #310 on 3/2/10, Individual #304 on 3/24/10, Individual #120 on 3/23/10, Individual #331 on 3/29/10, Individual #505 on 4/14/10, Individual #505 on 6/25/10, Individual #505 on 6/4/10, and Individual #324 on 6/17/10.	

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		The clinical pharmacist stated the third page of the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" forms were completed after-the-fact. The clinical pharmacist would review how the individual was monitored (e.g., vital signs frequency), and pre-treatment sedation medication would also be reviewed for frequency of vital signs. The clinical pharmacist was aware of some "stat" medications that had been given in June and July, but had not seen the "Face-to-Face" forms for review and comment. The system did not seem to be working well. There was at least a two-month delay before the clinical pharmacist saw the form for comment. The psychologist, QMRP, and other team members would benefit from the expertise of the clinical pharmacist, but this input was not being obtained in a timely manner. It is recommended that departments meet to review the route and timing of these forms to ensure appropriate review, completion, and follow-up.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The prescribing medical practitioner reviewed and signed off on 22 of the 24 QDRRs (92%) listed with regard to Section N.3 of the SA. In only two reviews, did the medical practitioner not agree with the pharmacist, and provided a reason on the actual QDRR form. However, as is discussed above with regard to Section J.11, a signature line had just recently been added for the psychiatrist's review. At the time of this review, only a limited number of QDRRs that were included in the sample for psychiatric services included documentation of review of the pharmacists' information. The modification of the form should assist in ensuring that there is clear documentation of the psychiatrists' review and response to the QDRRs, and relevant recommendations. At the Pharmacy and Therapeutics Committee Meeting of 4/30/10, changes in the QDRR were reviewed. Instructions included: "each DRR must be reviewed by the home practitioner and signed. There will be boxes to check 'I agree' or 'I disagree' with the pharmacist's recommendations and a place for comments. If the individual has polypharmacy for psychotropic drugs, the consulting psychiatrist will need to review and sign the DRR as well. The new form will be in use beginning May 3, 2010." It was confirmed at the Pharmacy and Therapeutics Committee Meeting of 7/28/10 that all practitioners were reviewing and signing the QDRR forms.	Noncompliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	Staff that had undergone appropriate training were completing MOSES and DISCUS ratings. Although there had been training, it is recommended that there be periodic inter-rater reliability testing to ensure the scores are valid across the campus. MOSES and DISCUS ratings were reviewed for 10 individuals, including the date of review of the results by prescriber. The following provides a description of the results of this review:	Noncompliance

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		▪ Individual #284 had the following completed: MOSES with RN examination dated 11/10/09, and prescriber review dated 2/8/10. This indicated approximately a three-month gap between the rating being completed and the prescriber reviewing the information. Considerable change in the individual could occur during that time. Ratings are most effective when reviewed and acted upon in a timely manner. The next rating was done on 5/4/10 with prescriber review on 5/10/10. Although the prescriber reviewed the information in a timely manner, the gap between ratings was lengthy - 11/10/09 to 5/4/10, almost six months. The exam type at the front of the rating indicated it should be completed every three months. The MOSES was not compliant with the three month rating being completed. The DISCUS was compliant, including a 2/2/10 rating with prescriber review 2/8/10, and a 5/4/10 rating with prescriber review 5/10/10. ▪ Individual #199's MOSES were rated on 4/14/10 with prescriber review 4/19/10, on 7/12/10 rating with 7/12/10 prescriber review; and DISCUS was rated on 4/16/10 with prescriber review 4/19/10, and 7/12/10 rating with 7/12/10 prescriber review. ▪ Individual #196's MOSES was rated on 2/1/10 and 5/3/10 with no confirmation of prescriber review; DISCUS ratings were submitted for 9/25/08 with prescriber review of 9/25/08, and 5/3/10 with prescriber review of 5/4/10. The 5/3/10 DISCUS recorded the last exam date was 2/1/10, but this was not submitted. ▪ Individual #517's MOSES was rated 12/20/09 with no confirmation of prescriber review, and 2/28/10 with prescriber review 4/27/10. This latter example indicated a two-month lapse between rating and review by the prescriber. Further, the MOSES was labeled as a quarterly scheduled review, and the last rating of 2/28/10 indicated there should have been a submission of a rated MOSES by 5/28/10. No rating for MOSES was submitted after 2/28/10. The schedule may have indicated the prescriber review of 4/27/10 with next due date 7/27/10, but that would have been a rating five months from the last, which defeats the three-month monitoring established for this individual. DISCUS was rated 12/20/09 with prescriber review of 1/25/10, and the last rating of 2/28/10 with prescriber review of 4/27/10. This indicated a concern similar to the MOSES rating schedule. ▪ Individual #469's MOSES was rated 4/2/10 with prescriber review of 4/13/10, and 7/15/10 rating with 7/23/10 prescriber review. The DISCUS was rated 4/2/10 with prescriber review of 4/13/10, and 7/15/10 rating with prescriber review of 7/23/10. ▪ Individual #323's MOSES was rated 4/2/10 with prescriber review of 4/13/10, and rated 7/15/10 with prescriber review of 7/23/10. The DISCUS was rated 4/2/10 with prescriber review of 4/13/10, and rated 7/15/10 with prescriber	

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		review of 7/23/10. ▪ Individual #76's MOSES was rated 3/25/10 with prescriber review of 4/13/10, and rated 6/21/10, with prescriber review of 6/28/10. The DISCUS was rated 3/25/10 with prescriber review of 4/13/10, and rated 6/21/10 with prescriber review of 6/28/10. ▪ Individual #228's MOSES was rated 4/2/10 with prescriber review of 4/13/10, and rated 7/5/20 with prescriber review of 7/13/10. The DISCUS was rated 4/2/10 with prescriber review of 4/13/10, and rated 7/5/10 with prescriber review of 7/13/10. ▪ Individual #164's MOSES was rated 6/2/10 with prescriber review of 6/4/10, and rated 7/14/10 with prescriber review of 7/14/10. The DISCUS was rated 6/2/10 with prescriber review of 6/4/10, and rated 7/14/10 with prescriber review of 7/14/10. ▪ Individual #268's MOSES was rated 4/14/10 with prescriber review of 4/19/10, and rated 7/12/10 with prescriber review of 7/12/10. The DISCUS was rated 4/16/10 with prescriber review of 4/19/10, and rated 7/12/10 with prescriber review 7/12/10. Out of 10 individuals with MOSES and DISCUS ratings submitted for review covering the most current three months, three were found to have irregularities and concerns. Compliance was found for seven of the 10 individuals (70%). It is recommended the "Policy: Psychiatry Services: Monitoring for Medication Side Effects" be fine tuned to reduce ambiguity as to the length of time acceptable between ratings completed and the prescriber review. Additionally, at the time of the review, the policy read: "The MOSES must be completed at least every 6 months and the DISCUS must be completed at least every 3 months." To reduce ambiguity, it is recommended the six months be changed to 180 days, and the three months to 90 days.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	Medication Adverse Reaction Reports were reviewed for Individual #180 dated 3/31/10, Individual #103 dated 3/31/10, Individual #287 dated 3/26/10, Individual #499 dated 4/8/10, Individual #520 dated 1/21/10, Individual #518 dated 4/29/10, Individual #54 dated 5/6/10, Individual #293 dated 5/6/10, and Individual #357 dated 5/19/10. The clinical pharmacist reviewed all cases (9/9 or 100%). In all cases, there was prompt clinical care. For the oral medications associated with the adverse effect, they were stopped and the individual was monitored. The following provides a brief summary of the actions taken to ensure the health and safety of the individuals: ▪ Individual #180 was admitted overnight to the Infirmary because of hypotension, a side effect of Clonidine started on 3/30/10. Clonidine was placed on hold. ▪ Individual #103 also was placed overnight in the Infirmary due to altered gait or	Substantial Compliance

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		balance after a recent adjustment upward of Dispersal. The dosage was reduced. ▪ Individual #287 had recently started Propranolol, and was admitted overnight to the Infirmary for increased respirations and lowered O2 saturation, and elevated blood pressure with irregular heart rate. The clinical pharmacist indicated that this was consistent with a drug side effect as well as drug-to-drug interactions with Propranolol. The individual was monitored overnight in the Infirmary and the medication was placed on hold. ▪ Individual #499, Individual #520, Individual #518, and Individual #54 all had local, minor expected reactions to IV Boniva for which they received treatment and monitoring. ▪ Individual #293 developed a temperature of 107.0° F tympanic, and he had lethargy and unsteady gait. He underwent external cooling with a fan pointed towards him. He was on Cogentin and this was discontinued. ▪ Individual #357 had a rectal temperature of 106.9° F and thrashing. She was hospitalized. Neuroleptic malignant syndrome was ruled out, and her malignant hyperthermia was of undetermined etiology. Medications were discontinued at the hospital, but it was not certain it was medication induced. The four IV complications of Boniva were discussed in follow up at the Pharmacy and Therapeutics Committee Meeting of 7/28/10. The cases of IV complications had the IV treatment in the Treatment Room. A primary care physician indicated these complications did not occur when the IV medication was given in the home. The Chief Nurse Executive agreed that the treatment could be given in the home as long as the nurse giving the injection had passed the annual competency exam for IV administration. Another suggestion was to ensure flushing with saline prior to the injection. In all cases there was timely identification, reporting, and treatment of the individual, and in the cluster of cases concerning IV Boniva, a systemic approach was implemented through the Pharmacy and Therapeutics Committee Meeting. The Pharmacy and Therapeutics Committee Meeting of 4/30/10 also discussed distribution of the ADR report to the PCP, which until then, had not been the practice. It was considered a learning experience for the PCP to learn of the side effects and adverse reactions of the drug effects severe enough to be considered an ADR. This systemic change and communication improvement was a direct result of the ADR reporting system. If the ADR report had not been completed and discussed at the Pharmacy and Therapeutics meeting, then the PCP would not be aware of the ADR.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the	With the addition of a clinical pharmacist to the pharmacy department, there had been the creation and implementation of drug utilization evaluations. The Pharmacy and Therapeutics Committee Meeting of 1/28/10 discussed the Drug Utilization Evaluation process. Sample size was discussed and agreed upon to be 20% or 20 individuals,	Substantial compliance

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	performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	whichever was greater. The Committee also agreed upon the acceptable level of compliance as 90% or above for any parameter. Less than that would require a plan of action and further follow up by the Committee. A Valproic acid (VPA) (any form) drug utilization evaluation report was submitted in April 2010. The audit sample included 22 records (24% of the total number of individuals receiving VPA). Included in the analysis were whether there was an appropriate indication for use, was there a contraindication, and various laboratory parameters specific to VPA. Ninety percent was the threshold for compliance. The only indicator that fell below the acceptable threshold was "VPA level every six months for behavior indication," and a plan of action was discussed further at the Pharmacy and Therapeutics Committee Meetings of April 30, 2010, and July 28, 2010. It was realized at the April 30, 2010 meeting that there were two different policies for following lab values when administering VPA, one when it was prescribed for seizures and one when it was prescribed for psychiatric diagnoses. The psychiatrists were asked to review the reason for the increased frequency for the psychiatric diagnosis and report back to the Committee at the next meeting. At the July 28, 2010 meeting, it was recorded that no reason could be found for a difference in monitoring, and the Committee unanimously approved the merger of the two protocols. Discussion on this same topic with the psychiatrists was documented in the Psychotropic Polypharmacy Review Committee minutes of 7/5/10. It was believed the two different policies caused confusion to the health care staff, and that was in part responsible for the indicator concerning lab value frequency to be less than the acceptable threshold level. The new protocol was to be entered into the Medical Policy manual, and the Nursing Department was to be educated on this new protocol. This demonstrated excellent follow through and an important practical outcome to the VPA DUE study. Plans were for it to be repeated in the third quarter to record evidence of an improving trend. The follow up "Proposed Surveillance Study 7/28/2010 for Valproic Acid (Depakene), Divalproex sodium (Depakote, Depakote ER, Depakote Sprinkles)" was to have the specific purpose "to merge the surveillance study parameters for seizure control and psychiatric use in Section 3 Medical 03-06.04." It will allow the lab testing to be streamlined to both meet the needs of the individual and to reduce confusion and errors in ordering of tests. In July 2010, a second DUE was completed concerning calcium supplements. Thirty-five records were reviewed (19% of the total number of individuals receiving calcium supplements.) The results were reported July 2010. Importantly, all of the records reviewed included calcium supplements for those with a diagnosis of osteoporosis/osteopenia and receiving bisphosphonates or calcitonin therapy (two medications indicated for treatment of osteoporosis/osteopenia.) In the analysis, there	

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		was only one indicator that fell below the threshold of 90%: "is the calcium supplement dosage adequate?" Compliance with this parameter was only 29%. Follow-up action was recorded in the July 28, 2010 Pharmacy and Therapeutics Committee Meeting. It was noted that as the study was being done, "the practitioners made immediate adjustments to the dosages," and additionally, this was also reviewed at the QDRR for all individuals. The DUE and the QDRR were predicted to have increased compliance considerably for this parameter. The Committee agreed that a follow-up study on adequate calcium supplementation would be completed prior to the next Pharmacy and Therapeutics Committee to determine if this has occurred. Again, this demonstrated that an excellent system was in place and benefiting the individuals residing at ABSSLC, as well as assisting the Medical Department in providing care. In discussions with the clinical pharmacist, there was intent to complete a DUE on a quarterly basis, and the last two quarters had completed DUE reports. However, the topics were not determined for the entire calendar year at the time of the discussion. The Pharmacy and Therapeutics Committee should develop an annual schedule of the medications to be reviewed and the frequency of the reviews.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	Medication error reports were reviewed for the following individuals/date error discovered: Individual #216 on 6/29/10, Individual#100 on 6/22/10, Individual #485 on 6/22/10, three reports for an unknown individual on 6/15/10, Individual #151 on 6/15/10, Individual #287 on 6/15/10, Individual #320 on 6/15/10, and two reports for Individual #151 on 6/17/10. These reports were indicative of the challenges ahead in improving the medication error rate. The following summarizes the types of errors that occurred: ▪ Three of the errors occurred during "training" or "training in process." ▪ Medications not administered included Ativan, topical silver nitrate application, and Promethazine. ▪ The unknown errors involved tablets of Propranolol 20 mg found loose in the drawer. It was unclear which individual should have received the tablets. ▪ Individual #151 had several medication errors. On 6/15/10, a dose of Famotidine was left over at autofill. The 6/17/10 errors occurred when a nurse was distracted by having to attend a meeting, and did not double-check the drawers. The individual did not get a dose of a multivitamin and mineral, and calcium with vitamin D. ▪ For Individual #320, and Individual #287, a tablet of Zyprexa remained at the end of the week that was signed off all days as having been given. The report "Monthly Errors by Type" indicated the error rate had increased from January 2010 with 69 errors, to May 2010 with 177 errors. This increase in errors likely is the	Noncompliance

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		result of more accurate reporting, and should not necessarily be reviewed as an increase in the actual number of errors. As the baseline report indicated, it appeared that the Facility had significant concerns with underreporting. As that report indicated, in order to ensure that adequate action was being taken to address medication errors, it was essential for more accurate reporting to occur. Although the numbers of errors should decrease over time, this initial spike in numbers should be viewed as a positive sign that more accurate reporting might be occurring. Of the 177 errors recorded in May 2010, 118 were omitted doses and 51 were wrong doses. The report "Monthly Errors by Category" indicated the majority of errors were categorized as unknown errors. According to this report, there had been no serious errors since January 2010. However, the meeting minutes from the Pharmacy and Therapeutics Committee, dated 4/30/10, indicated that two serious medication errors had occurred in the information submitted to that Committee, although the two serious medication errors may have occurred prior to January 2010. The report "Sorted by Node" indicated there were two main sources of error, administering and documenting the medication. The report "Sorted by Severity" indicated the majority of errors were Category C (an error occurred that reached the consumer, but did not cause consumer harm). The report "Data Sorted by Shift" indicated a substantial number of medication errors occurred in which the shift could not be determined. The report "Errors by Unit" indicated there was fluctuation in the number of errors in the units over time. Unit 2 had 99 errors in 12/09, but this had decreased to one error in 5/10. Unit 3 had one error reported in 1/10, but 84 errors in 5/10. Unit 5 reported one error in 2/10, but 12 in 5/10. Unit 6 reported six errors in 2/10, and 34 in 5/10. The Facility continued to seek answers to the continued concern of medication errors. The Pharmacy and Therapeutics Committee meeting of 4/30/10 indicated there was a spike in the medication errors reported due to including left over medications (overages). This had led to an increase in the unknown errors. At this meeting, there were reported to have been two serious medication errors, and these required admission to the Infirmary for observation. There was no report of harm to either individual. The Committee meeting minutes commented on the spike in variances in the cottages during the month of March 2010. At that time, nurses were covering three homes instead of two, while new nurses were being fully trained. The performance plan indicated the goal of fully staffed and trained nurses. In the case of serious medication errors, the nurse was to have retraining to include a successful medication pass while being observed before being allowed to function independently. The Medication Error Committee also tracked errors and sought resolutions to the problem of medication errors. In the January 27, 2010 minutes, there was a discussion	

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		about errors related to overages at the end of the autofill week. Nursing indicated that it could not be determined when the actual omission or wrong dose occurred. The date reported was the date of discovery, which occurred at the subsequent autofill. In response to this, the March 3, 2010 Medication Error Committee documented that when there were unknown errors, as in overages at the time of autofills, that nursing had attempted to identify and counsel groups of nurses who were potentially involved. Additionally, pharmacy was completing checks before autofill was distributed. According to the minutes, there were two pharmacy variances for January. It is recommended that a double check is done on all autofills to ensure there are no variances that originate from the pharmacy department. This could be done by either pharmacy staff, or nursing at the time of arrival to the units. If nursing and pharmacy do the double check on the unit together, then that is an added benefit in knowing the exact amount actually delivered to a unit. If a representative from each department is available to count at the same time, then there would be agreement as to how much is delivered. Thereafter, overages and shortages would fall to the nursing department to resolve. There was the additional concern discussed at the April 28, 2010 meeting that pharmacy may be sending more doses than it uses, incurring an overage, which may not reflect medication errors. It is recommended that pharmacy supply the precise required number of doses for a week, and that this be double-checked, one time at the pharmacy and one time on the unit. Because of the number of medication errors and the concern about autofill overages, it is recommended temporarily or long-term that only one week's supply of medications be distributed at a time. This would reduce the time required to double check in any one week. It also would reduce problems related to storing medications. According to the 4/28/10 meeting minutes, this was a problem in some of the homes. Additionally, to improve accountability and counting accuracy, it is recommended that medications not be "packaged" in multiple week batches. It would be easier to track medications and provide accurate medication counts to reduce or find actual errors if distribution of medication was limited to one week, and the multiple week batching of medications was eliminated. The April 28, 2010 meeting also discussed changes in how medication errors were counted. From the discussion, there was the concern that there was under reporting of medication errors, especially the unknown errors. Reportedly, this was corrected by the time of the meeting. This had led to an increase in the unknown error rate. As a result, the baseline method of determining medication errors had changed which had made it difficult to compare rates over time. That the medication error rate was 177 in May 2010, dropped to 130 in June 2010, and increased to 268 in July 2010 suggested the need to pursue all routes in resolving the problems related to the definitions of variances, as	

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		well as the accurate reporting of variances. The March 3, 2010 meeting also discussed adding GT/JT procedures to the observation monitoring tool, although it did not include specifics. This would be an important advance and is highly recommended, considering the number of tube complications and medication errors. This may assist in lowering the medication error rate, and assist in decreasing some of the tube complications, such as clogs. It would add more accountability to this part of nursing. The Medication Error Committee of January 27, 2010 also noted that some of the medication carts needed repair and could not be locked. This was not reported in any follow-up minutes, suggesting no progress has been made. Unlocked medication carts are inherently hazardous. It is difficult to ensure a nurse never leaves a medication cart if it is unlocked. If the cart is in a hallway or room and the nurse is called to an emergency, this provides an opportunity for individuals to gain access to the medications and cause self-harm. To provide a healthful and safe environment, it is recommended that the medication carts be repaired and locks replaced, and that minutes reflect the date of these repairs. The Medication Error Committee of 3/31/10 discussed flushing before administration of medications. The current procedure at ABSSLC did not include this as part of the procedure. However, it is imperative for flushing to occur to ensure medications are not mixed with formula or other medications, and the simplest way is to flush the tube prior to administration. This may be one of the causes of some of the G-tubes repeatedly clogging at ABSSLC.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. A software program should be provided for use by the clinical pharmacist in the QDRR process to allow comparison of data, and to be able to complete the tasks required in a more efficient manner.
2. The Quarterly Drug Regimen Reviews should include information concerning whether the drug level was in the normal range, below the therapeutic range, or above the range.
3. The Dental Director should be a voting member of the Pharmacy and Therapeutics Committee. It is also recommended that a psychiatrist be a consultant member of the committee.
4. Performance plans should be monitored to ensure the completion of the steps agreed upon at the Psychotropic Polypharmacy Review Committee.
5. To address concerns with the "stat" medication face-to-face documentation and review process, the department directors from the departments that are part of the current system should meet to review and streamline the process so that the clinical pharmacist has the opportunity to provide information and advice at the time of the need for a "stat" medication, and if not at the time of the need, then within a few days time.

6. There should be periodic inter-rater reliability testing to ensure scores on the MOSES and DISCUS are valid across the campus.
7. The policy on monitoring of medication side effects should be revised to reduce the length of time between the rating being done and the prescriber review. Also, to create clarity, consideration should be given to changing the time intervals from six months to 180 days, and three months to 90 days.
8. A double check system should be instituted for all autofills to ensure there are no variances that originate from pharmacy. There should be a check upon arrival to the unit by both a pharmacist and nurse.
9. The pharmacy should deliver the precise number of doses needed for a one-week supply only.
10. If steps have not already been taken to address the concern of unlocked medication carts, they should be taken immediately. The resolution of this issue should be documented in the committee minutes.
11. The nursing policy should be changed to include flushing of G and J-tubes prior to administration of medications.
12. The Pharmacy and Therapeutics Committee should develop an annual schedule of the medications to be reviewed.
13. The Medication Error Committee should conduct regular analyses regarding medication errors to identify trends and implement plans of correction aimed at the prevention of such errors.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Physical Nutritional Management (PNM) Team Members, not dated; o Physical Nutritional Management Plan (PNMP) Clinics for multiple individuals, 1/10 through 7/10; o List of individuals at Nutritional Risk, not dated; o Summary of Nutritional Management Team (NMT) Minutes, 1/10 through 6/10; o Meeting Participants and Health Care Provider Statement for multiple individuals, 2/10 through 7/10; o NMT Review and Recommendations, dated 5/20/10 and 6/20/10; o State Supported Living Center Policy for At Risk Individuals, dated 10/5/09; o Health Risk Assessment Tool for Aspiration/Choking, revised 12/7/09; o PNMP Roster list, dated 7/2/10; o Non-PNMP Roster list, dated 7/7/10; o Assessment/Evaluation Forms, including: Seating System Assessment (blank), not dated; OT/PT Annual Evaluation (blank), not dated; Berg Balance Test-Evaluation (blank), dated 6/25/07; Cratty Perceptual-Motor Test/Evaluation (blank), not dated; Performance Oriented Assessment of Balance and Gait, dated 11/03; Occupational Therapy/Speech Therapy (OT/ST) Eating Evaluation/Nutritional Management Plan (blank), revised 2/10; o PNM Assessments and Updates for multiple individuals, dated 2/10 through 7/10; o Personal Support Plans (PSP) for multiple individuals, dated 7/09 through 6/10; o Forms, including: PNMP Training form (blank), dated 12/13/09; Sensory Diet Training form (blank), dated 2/9/10; Mealtime Observation form (blank), revised 1/07; Competency Training list (blank), not dated; PNMP Monitoring form-Routine (blank), not dated; Sterident Monitoring Log (blank), revised 10/18/06; Wheelchair Check sheet (blank), not dated; Habilitation Therapy Wheelchair/Equipment log (blank), dated 3/04; o PNMP Training forms, dated 3/10 through 5/10; o Adaptive Equipment Program Review Objective Data Sheet (blank), revised 5/13/10; o List of Individuals with Weight Loss greater than or equal to 10%, 1/10 through 7/10; o All-Inclusive Risk Listing, 12/09 through 6/10; o List of Individuals with Body Mass Index (BMI) greater than or equal to 30, not dated; BMI less than or equal to 20, not dated; o OT/ST Eating Evaluation/Nutritional Management Plan (blank), revised 2/10; OT/ST Eating Evaluation/Nutritional Management Plan-Addendum (blank), not dated; o PNMPs for multiple individuals, dated 1/09 through 6/10; o Competency-based Training list, dated 6/22/10; o OT/ST Eating Evaluation/Nutritional Management Plan, dated 6/15/10; o OT/ST Eating Evaluation/Nutritional Management Plan Addendum, dated 4/19/10;

	○ Documentation Report of In-service Training, dated 6/8/09 and 6/25/09; ○ Adaptive Equipment and Programming for multiple individuals, not dated; ○ List of Individuals with Adaptive Eating Equipment and Positioning, dated 1/20/10; ○ PNMP Tracking, dated 5/10 and 6/10; ○ Revision PNMP Tracking, 5/10 through 7/10; ○ List of individuals recommended to use Steridents Toothbrush, revised 7/8/10; ○ Dining Plan Roster for 2010, dated 7/13/10; ○ List of Individuals with Modified Diets, 1/10 through 7/10; ○ List of Individuals with Texture Modification, 1/10 through 7/10; ○ List of Individuals with Choking Incidents, 7/09 through 7/10; ○ Communicable Disease Report for multiple individuals, dated 5/10; ○ Skin Integrity Data Tracking, 9/09 through 2/10; ○ List of Individuals with Injuries, 7/09 through 7/10; ○ List of Individuals with G-Tubes (gastrostomy)/J-Tubes (jejunostomy), and/or Tracheostomies, dated 7/3/10; ○ List of Individuals involved with Modified Barium Swallow Studies (MBSS), 7/10 through 6/10; ○ Meal Serving Times-schedule, dated 7/10/10; ○ Health Status Team Schedule, dated 8/10; ○ Lifting Class procedure, not dated; ○ New Employee Pre-Training (NEPT) checklist (blank), not dated; ○ OT DADS, not dated; ○ Mealtime set-up for Visually Impaired/Blind, not dated; ○ When to Call OT, not dated; ○ Secrets of Mealtime Success, revised 6/08; ○ 10 Top Things to Do to help people with Visual problems in their homes, not dated; ○ Choking Incident Follow-up Policy/Procedure, revised 7/09; ○ Evaluation of: Stand/Pivot Transfer (blank), not dated; Two-Person Manual Lift (blank), not dated; Three-Person Side-by-Side Lift (blank), not dated; Mechanical Lift, not dated; Bathing Trolley (blank), not dated; Lifting/Transferring Written Assessment (blank), not dated; NEPT Nutritional Management and Low vision/Blindness Test, not dated; ○ Competency-based Training list (blank), not dated; Mealtime Observation (blank), revised 1/07; PNMP Training form (blank), dated 12/13/09; Sensory Diet Training form (blank), dated 2/9/10; PNMP Monitoring form-Routine (blank), not dated; ○ List of Competency-based Training Sessions pertaining to PNM Skills, 6/09 through 6/10; ○ Percentage of Total Employees who require PNMP training, not dated; ○ Presentation Book for Section O; ○ Notes regarding ABSSLC training of Home Program Techs and PNMP Coordinators, dated 8/8/10; ○ Training Topics for New Home Program Technicians, not dated; ○ PNMP Coordinator Training Roster, multiple dates; ○ Habilitation Therapies Department of Aging and Disability Services Vision and Mission

	Statement, not dated; o Gastroesophageal Reflux (GER) Protocol, dated February 2000; o Dining Plans, not dated; o Post Test for "5 Keys to Mealtime Safety" In-service, not dated; o New Employee Post Test (NEPT) Nutritional Management and Low/Vision Blindness Test, not dated; o What is GERD?, not dated: o Food Texture and Liquid Consistencies, not dated; o When to Call OT, not dated; o PNMP Monitoring Form-Routine, not dated; o PNMP Training Form, dated 12/13/09; o Wheelchair Check Sheet, not dated; o Technician Training for Range of Motion (ROM) Programs, not dated; o Meal time set-up for Visually Impaired/Blind, not dated; o Choking Investigations for Individual #396, dated 7/23/09; and Individual #241, dated 6/9/10 and 7/1/10; o Current caseloads and home assignments of OTs/PTs/SLPs, not dated; o The following requested documents: Eating Evaluation, OT/PT/SLP Assessment, Nutrition Assessment, Medical Assessment, OT/PT/SLP consultations for the past year, outside consultations for the past year, PSP and PSP Addendums for the past year; PNMP (current and revised) with pictures for the last year; NMT Individual Record with recommendations, NMT person-specific monitoring, Nutritional At Risk Assessment completed by the NMT, PNMP Clinic notes for the past year, PNMP monitoring for June-July 2010, Competency-based training for staff, daily schedule, HST Risk Assessment for all categories, Infirmary/ER/Hospital Discharge Summary and Dining Plan/Diet Card for the following individuals: Individual #241, Individual #148, Individual #503, Individual #208, Individual #8, Individual #231, Individual #289, Individual #145, Individual #348, Individual #353, Individual #540, Individual #100, Individual #409, Individual #511, Individual #65, Individual #464, and Individual #457; o The following requested documents: Eating Evaluation, OT/PT/SLP Assessment, Nutrition Assessment, Medical Assessment, OT/PT/SLP consultations for the past year, outside consultations for the past year, PSP and PSP Addendums for the past year; PNMP (current and revised) with pictures for the last year; NMT Individual Record with recommendations, NMT person-specific monitoring, Nutritional At Risk Assessment completed by the NMT, PNMP Clinic notes for the past year, PNMP monitoring for June-July 2010, Competency-based training for staff, daily schedule, HST Risk Assessment for all categories, Infirmary/ER/Hospital Discharge Summary and Dining Plan/Diet Card for the following individuals: Individual #7, Individual #205, Individual #154, Individual #106, Individual #272, Individuals #504, Individual #491, and Individual #357, Individual #108, Individual #400, Individual #285, and Individual #386; o The following requested documents: OT/SLP Assessment, Nutritional Assessment, Nursing Assessment, OT/PT consultations for the past year, PSP and PSP Addendums for

	the past year, NMT Individual Record with recommendations, Pleasure/therapeutic feeding program, therapy progress notes for pleasure/therapeutic feeding program, person-specific monitoring for June-July 2010, PNMP with pictures, and Modified Barium Swallow (MBS) consultation for the following individuals: Individual #85, Individual #296, Individual #362, Individual #77, Individual #257, Individual #435, Individual #431, Individual #70, Individuals #489, Individual #49, Individual #101, and Individual #512; and o The following requested documents: NMT Individual minutes/recommendations, PNMP Clinic notes, PSP, OT/PT/SLP Assessments, PNMP with pictures and Infirmary/ER/hospital discharge summary for the following individuals: Individual #161, Individual #249, Individual #419, Individual #90, Individual #475, and Individual #175 ▪ **Interviews with**: o Glen Funky, Physical Therapist (PT), Director of Habilitation Therapy; o Karen Mayfield, Lead PT; o Bobbie Holden, Lead Occupational Therapist (OT), NMT Member; o Debbie Sessions, MS, CCC-SLP, Coordinator of Nutritional Management Team (NMT); o Tricia Reyes, MS, Registered Dietitian (RD), NMT Member; o Nicole Spalding, RD, Licensed Dietitian (LD), NMT Member; and o Pat Johnson, Registered Nurse, NMT Member; ▪ **Observations of**: o Observations in homes 5961, 5962, 5971, 5972, 6330, 6460, 6450, 6700, 6690, 6521, 6350, 5972, 6500, 6370, and 6480; o Observations in Vocational and Activity Centers; and o Nutritional Management Team Meeting, on 8/4/10
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for ABSSLC did not include this component, the POI for Section O identified compliance and/or non-compliance with identified indicators. ABSSLC identified compliance with some indicators in Section O. However, based on the Monitoring Team's review, the Facility was not in compliance with these components of the SA. Additional information and individual examples are contained in the section below that addresses Section O of the SA. Examples of indicators that were rated in compliance, but non-compliance was found by the Monitoring Team included: The POI for Section O.1.3 documented compliance with the following indicator: "100% of records show that the PNM team meets regularly to address change in status, assessments, clinical data and monitoring results." A review of 29 records documented the PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of interventions to minimize identified health risks. The POI for Section O.1.4.a-e documented compliance for the indicator: "100% of records show that regularly scheduled Physical Nutritional Management Team meetings will be held to identify all individuals for physical and nutritional risks, to recommend and formulate interventions, to review plans, provide follow-up and provide equipment for mobility and positioning." The Monitoring Team confirmed that the

	PNMT (NMT) met on a regularly scheduled basis, but the PNMT (NMT), as stated above, did not meet the criteria set forth in the SA, nor did the PNMT (NMT) complete a timely and proactive comprehensive assessment leading to the development of interventions to minimize identified health risks. The POI for Section O.2.4.a-I.l-n documented compliance for assessment indicators. The Monitoring Team did not find compliance with these indicators, because the PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of interventions to minimize identified health risks. The POI for Section O.3.9 documented compliance for the following indicator: "100% of records reviewed show that PNMPs are developed with input from the PST, home staff, medical and nursing staff and the physical and nutritional management team." The Monitoring Team did not support this finding of compliance as the review of individual PSPs did not document attendance by therapists, medical staff, and/or direct support professionals. The POI for Section O.3.11.a-f. documented compliance for the following indicator: "100% of records reviewed show that PNMPs and dining plans will be revised as needed to ensure that current information addresses positioning, risks for choking or aspiration, reducing the effects of gastroesophageal reflux, to minimize the risk of dangerous behavior such as stealing food or eating too fast, diet texture and other areas that affect safety and promote a pleasant dining experience." The Monitoring Team identified a number of individuals with identified risk factors that did not have a PNMP developed. The POI for Section O.3.12, O.3.13 and O.3.14 documented compliance for: "PNMPs are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results; congruency between strategies, interventions, and recommendations contained in the PNMP and the concerns identified in the comprehensive assessment and PNM supports and techniques should be based on the assessment and should be clinically justifiable and appropriate for the individual." As stated above and throughout this report regarding Section O, the PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of interventions to minimize identified health risks. The POI for Section O.4.7 and O.4.8 documented compliance for: "staff who are responsible for ensuring correct positioning and alignment are trained and monitored for performance and instructions show positioning for individuals before, during and after meals promote optimal alignment and reduce risks. Staff will be trained in the use of plans." Observations by the Monitoring Team did not confirm staff competency in placing individuals in optimal alignment before, during and after meals. The POI for Section O.5.1 through O.5.4 documented compliance for: "relevant staff are provided with general competency-based foundational training related to all aspects of PNM by clinically trained staff; ABSSLC has provided competency-based training for home supervisors and/or mealtime monitors initially and at least annually; performed competency-based training for DCS on mealtime and positioning plans as part of new hire training and annually thereafter; and competency-based training focuses on the

	acquisition of skills or knowledge and is represented by the return demonstration of skills or by pre/post test, which may also include return demonstration as applicable." Reports submitted by ABSSLC did not document that all required staff had received training in PNM, which should be competency-based to provide foundational knowledge and skills, including written testing and skills-based performance check-offs. The POI for Section O.5.11 documented compliance for the following indicator: "records reviewed and observations/interviews completed show that staff are trained prior to working with individuals and retrained as changes occur with the PNMP." The Monitoring Team find compliance with this indicator because record review did not support staff had received competency-based training on PNMPs. In addition, documentation did not support that staff were re-trained when there was a revision to the PNMP. The POI for Section O.6.1, O.6.2, and O.6.6 documented compliance for the indicator: "a system is in place that monitors staff implementation of PNMPs, monitors implementation of plans by direct contact staff regularly as scheduled and monitors will include members of the PNM team and other professionals, home and administrative staff as assigned." ABSSLC submitted PNMP monitoring forms, but this was not consistent across the 29 individuals who were reviewed. In addition, no documentation was submitted to show that ABSSLC monitoring policies/procedures had been revised to define the current monitoring process. As discussed above with regard to Section E of the SA, the monitoring tools for Sections O, P, and R will need to be revised to facilitate monitoring by the Facility, include indicators that clearly define the expectations and ensure reliability across reviewers, and have corresponding instructions/guidelines developed.
	Summary of Monitor's Assessment: Based on a review of PNM Team meeting minutes (which the Facility refers to as the NMT), the standing members were a Speech Language Pathologist (Coordinator of the NMT), two Registered Dietitians, an Occupational Therapist (Lead OT), and a Registered Nurse. There were no ancillary members attending the PNMT (NMT). The composition of the PNMT (NMT) did not meet the requirements of the SA, because a Physical Therapist was not a member of the team. As was discussed by the Monitoring Team with members of ABSSLC's management team, at the time of the review, the PNMT (NMT) was not fulfilling its responsibilities, and as a result, individuals were at risk. The PNMT should have but was not identifying the individuals with the most complex health, physical and nutritional support needs, and completing a comprehensive assessment, leading to the development of individual-specific strategies to minimize their identified high risk health concerns. These strategies should have included individual-specific criteria, resulting in the development of functional outcomes. The outcomes should have been being tracked by the PNMT to determine the efficacy of individual problem resolution, and the success and/or the lack of success for the strategies implemented. The outcomes and criteria should have been clearly documented and utilized for monitoring. The PNMT also should have been responsible for determining not only the efficacy of the individual-specific outcomes, but providing analysis on a systems level to develop and monitor thresholds/triggers for integration into the Facility Risk

	Management and Quality Improvement Systems. Given the large caseloads and other responsibilities of the therapists assigned to the PNMT (NMT), it made it virtually impossible to implement a PNMT per the requirements of the SA. Based on policy review (State and Facility) and record review, a process that identified individuals with PNM concerns was not defined sufficiently. As a result, individuals who should have been reviewed and supported by the PNMT (NMT) were not. As stated in the baseline report, the Physical and Nutritional Management Policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs were not being implemented as written. There were no revisions to this policy, nor did the Facility's POI address changes to monitoring. Quality Improvement/Enhancement, HST minutes, and Mortality Review Committee minutes did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM (NMT) that could be analyzed to identify and ensure the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. In addition, PNMT members should be actively involved in internal mortality reviews as a learning process as well as a mechanism for improving supports to individuals with the most complex health, physical and nutritional support needs. The PNMT (NMT) had reviewed six individuals who were deceased prior to their deaths, but as stated in the baseline report, these reviews consisted of a chart review leading to recommendations that were generic in nature. The PNMT (NMT) did not provide an intensive, interdisciplinary problem-solving approach for these individuals with complex health, physical and nutritional support needs. A review of individuals who had died within the time period of July 2009 to June 2010 identified 10 of the 24individuals' causes of death as respiratory failure, pneumonitis due to inhalation of food or vomitus, acute respiratory failure, and pneumonia. An extensive, critical review of the mortality reports, including recommendations, by the PNM Team would be an important learning strategy to identify future person-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs but, most importantly, for individuals at the highest health risk levels. Based on the review of 12 individual records who were enterally nourished, none of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	Due to the multiple requirements included in this provision of the SA, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the SA, the following summarizes the review of the requirements related to the Physical and Nutritional Management Team, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The assessment and planning processes in which the team is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the SA. The PNM team consists of qualified Speech Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietician (RD), and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse Practitioner (RNP)]. Based on a review of PNM Team meeting minutes, the standing members were a Speech Language Pathologist, 2 Registered Dietitians, an Occupational Therapists and a Registered Nurse. There were no ancillary members attending the PNMT (NMT). The composition of the PNMT (NMT) did not meet the requirements of the SA, because a Physical Therapist was not a member of the team. Based on a review of PNM (NMT) Team attendance records and meeting minutes from 1/4/10 to 6/23/10 (29 meetings), there was documentation of 100% attendance by the Speech Language Pathologist, 80% attendance by the Occupational Therapist, 97% attendance by one Registered Dietitian, 90% attendance by the other Registered Dietitian and 100% attendance by the Nurse. There were no designated stand-in members identified in the attendance records. At the time of the review, the current members of the PNMT (NMT) carried significant caseloads and additional responsibilities beyond being members of the PNMT. ABSSLC had two dietitians providing nutritional support to 452 individuals. Their caseloads were in excess of 200 individuals, in addition to their responsibilities with the PNMT (NMT). The Occupational Therapist on the PNMT (NMT) had a caseload of 202 individuals, was the Lead Occupational Therapist, and until recently, supervised the PNMP Coordinators (10 positions) and provided direction to Home Program Technicians (13 positions). The PNMT (NMT) Coordinator (Speech Language Pathologist) carried a caseload of 102 individuals. The PNMT (NMT) meeting scheduled for the week of the on-site compliance review was scheduled from 11:00 a.m. to 5:00 p.m. Based on record review, on average, the PNMT (NMT) would review 15 to 18 individuals every meeting. The current caseloads of these professionals made it virtually impossible to implement a PNMT per the requirements of	Noncompliance

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	or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	the SA. If the Facility established a dedicated PNMT, there would be a significant impact on the remaining therapists and dietitians, because their caseloads would significantly increase without the addition of positions. PNMT members should not carry a significant caseload as their responsibility will be to identify the individuals with the most complex health, physical and nutritional support needs, complete a comprehensive assessment which will lead to the development of individual-specific strategies to minimize their identified high risk health concerns. These strategies must have individual-specific criteria leading to the development of functional outcomes. The outcomes must be tracked by the PNMT to determine the efficacy of individual problem resolution, and the success and/or the lack of success for the strategies implemented. The outcomes and criteria must be clearly documented and utilized for monitoring. The PNMT will be responsible for determining not only the efficacy of the individual-specific outcomes, but providing analysis on a systems level to develop and monitor thresholds/triggers for integration into the Facility Risk Management and Quality Improvement Systems. As was discussed by the Monitoring Team with members of ABSSLC's management team, at the time of the review, the PNMT (NMT) was not fulfilling these responsibilities, and as a result, individuals were at risk. Review of Curriculum Vitae(s) (CVs) submitted for four (SLP, OT and two RDs) of the five PNM (NMT) Team standing member showed they had five years of experience in their respective fields. These therapists and registered dietitians were licensed to practice in the state of Texas, per report. A Curriculum Vita was not submitted for the Nurse on the PNMT (NMT). As a result, the Monitoring Team was not able to substantiate the qualifications for this PNMT (NMT) Team member. Review of PNM (NMT) clinical instruction documentation submitted revealed that the Nurse PNM (NMT) Team member did not participate in training and professional development within the last 12 months related to physical and nutritional supports. The SLP, OT and two RDs submitted continuing education documentation. PNMT standing members (not just therapists) should attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of supports to individuals with the most complex physical and nutritional supports needs. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> Based on a review of 17 individual records, none of them (0%) included documentation to support the PNM (NMT) Team did meet regularly to address change in status, assessment, clinical data and monitoring results. The records reviewed included: Individual #241, Individual #148, Individual #503, Individual #208, Individual #8, Individual #231, Individual #289, Individual #145, Individual #348, Individual #353, Individual #540, Individual #100, Individual #409, Individual #511, Individual #65,	

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		Individual #464, and Individual #457. The individual record sample was drawn from lists of individuals at risk based on the following criteria: ▪ Individuals who had Emergency Room visits; ▪ Individuals who had hospitalizations; ▪ PNM (NMT) Team meeting minutes; ▪ Individuals with active pressure ulcer within the last six months; ▪ Individuals with severe dysphagia; ▪ Individuals with chronic constipation or who experienced fecal impaction within the last six months; ▪ Individuals with unexplained weight loss or Body Mass Index (BMI) ≤ 20; ▪ Individuals ≥ BMI of 30; ▪ Individuals who experienced a choking incident which required abdominal thrust within the last six months; ▪ Individuals with a diagnosis of aspiration pneumonia; ▪ Individuals who had experienced significant falls related to transfers and/or ambulation; ▪ Individuals with chronic respiratory infections; ▪ Individuals with chronic dehydration; ▪ Individuals with a diagnosis of osteoporosis and/or osteopenia; ▪ Individuals who experienced a fracture; and ▪ Reviewer observations of mealtime, positioning, transfers, medication administration, tooth brushing, personal care, and functional communication. Individual examples of where the PNM (NMT) Team did not regularly address change in status, development of comprehensive assessment, review of clinical data and monitoring results included: ▪ Individual #241 had experienced two choking incidents between July 2009 and the present. The NMT reviewed her on 5/12/10 (Initial Review) due to a recent pneumonia and Modified Barium Swallow Study, 6/11/10 (Monthly Review), and 7/28/10 (Annual Review). The NMT recommended continue oral eating, continue current diet and feeding techniques, and diet order change to low cholesterol anti-reflux 1200 calorie pureed divided into five small meals. An Eating Evaluation/Nutritional Management Plan was completed on 7/15/10 that addressed her oral motor function problems, choking risks, voice quality, hand dominance, type of grasp, head control, trunk control, observed eating status, MBS and summary. The evaluation included recommendations for position, eating status, food/liquid texture, adaptive equipment, and suggested eating techniques. Although it is positive that these steps were taken in July 2010, Individual #241 had been diagnosed with pneumonia on 3/31/10 per the	

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		Communicable Disease Report (5/1/09 to 5/31/10). In addition, as mentioned previously, she had had two choking incidents since July 2009 that had not been addressed by the PNMT (NMT). The PNMT (NMT) did not complete a timely and proactive comprehensive assessment to address her ongoing health risks, as well as identified physical and nutritional support needs. ▪ Individual #148 was admitted to the Infirmary on 1/16/10, with the diagnoses of dehydration and hypernatremia. On 3/2/10, he was admitted to the Infirmary with diagnoses of "anorexia, alt[ered] mental, and vomiting." The PNMT (NMT) did not review him on 4/9/10, 4/13/10 and 4/16/10 because he was "currently in Infirmary and charts not available." The PNMT (NMT) reviewed him on 4/28/10 with the following recommendations "continue oral eating and continue current diet and feeding techniques." The PNMT (NMT) did not complete a timely and proactive comprehensive assessment to address his ongoing health risks, as well as identified physical and nutritional support needs. ▪ Individual #503's Eating Evaluation/Nutritional Management Plan, dated 2/22/10, documented that she "has also been having difficulty with a dry cough and vomiting over the past several months." The Eating Evaluation stated she has "the following medical diagnoses that could impact mealtime functioning and nutritional status: seizure disorder, increased lipids and triglycerides, hypothyroidism, chronic kidney disease (stage III) and constipation." A Physical Therapy Update, dated 2/18/10, indicated "in order to try to reduce her discomfort and decrease the excess coughing/vomiting, it was recommended that her head of bed be elevated. A work order will be generated for the construction of a wedge for her bed." Her PNMP, revised 4/8/10, did not address elevation of her bed. On 4/23/10, Individual #503 was admitted to the Infirmary for vomiting. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her ongoing vomiting and after her Infirmary admission for vomiting. ▪ Individual #208 was admitted to the Infirmary with the following diagnoses on the following dates: UTI, mild hydration, on 1/5/10; fever, on 6/18/10; vomiting, on 7/10/10; and vomiting/hypoxia, on 7/12/10. The Communicable Disease Report for Aspiration Pneumonia (5/10/09 to 5/31/10) documented Individual #208 had been diagnosed three times with aspiration pneumonia, on 8/2/09, 9/12/09 and 12/4/09. The Communicable Disease Report for Pneumonia documented that Individual #208 had been diagnosed with pneumonia on 5/20/09. The PNMT (NMT) reviewed Individual #208 on 9/2/09 and 9/30/09, with the following recommendations: oral eating is not recommended; continue enteral feedings and continue current formula. He was a Risk Level 3 – Low Risk, but had been diagnosed with aspiration pneumonia in August and September 2009. He was reviewed on 10/6/09, and his risk level was changed to 1 – High Risk. The recommendation was "due to increasing	

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		medical compromise and lack of success in alleviating vomiting, please consider having the complete team of physicians convene with dietitians to review chart and consider all available interventions." Subsequent PNMT (NMT) reviews did not discuss the status and/or outcome of this recommendation. The 11/2/09 review stated the reason for follow-up was "vomiting, pneumonia and intervention meeting." It was not clear if this meeting was related to the previous recommendation. PNMT (NMT) reviews (nine reviews after 10/6/09) continued to document vomiting issues, diagnosis of pneumonia, and weight issues. His PNMP, revised 6/23/10, did not state that his bed should be elevated at all times, and there were no instructions for the use a Steridент tooth brush as recommended in the OT/ST Eating Evaluation Nutritional Management Plan, fated 7/29/08. PNMT (NMT) review indicated: "please review 11/09 GI and note recommendations if not previously noted." These recommendations were not documented. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #8's PSP Addendum, dated 3/18/10, documented she received a "serious injury of broken right neck of humerus (upper arm bone) that occurred on 3/11/10. The PNMT (NMT) did not review Individual #8 following her fracture. ▪ On 2/2/10, Individual #289 was admitted to the Infirmary with the following diagnoses: lethargy and fever. The Communicable Disease Report for Aspiration Pneumonia (5/1/09 to 5/31/10) documented a diagnosis of aspiration pneumonia on 2/2/10. His BMI score was 16, which placed him in the moderately underweight category. Individual #289's moderately underweight status placed him at risk for, but not limited to, compromised immune function, respiratory disease, digestive disease, and increased risk of falls and fractures. His underweight status would not provide adequate energy for daily activities. His Modified Barium Swallow, dated 4/12/10, documented severe dysphasia. The PNMT (NMT) reviewed him 10 times from 9/2/09 to 7/14/10 with the following recommendations: continue oral eating, continue current diet and feeding techniques, "due to weight loss below RWR (recommended weight range), please consider adding Periactin or other appetite stimulant to increase meal acceptance" (11/10/09); "please convene PST with physician present to discuss the possibility of adding Periactin or other appetite stimulant to increase mall acceptance" (12/30/09); "please write order for : ProState 64 30 ml BID, please order Prealbumin and fax results to dietitian, and due to excessive salivation, please consider restarting Cogentin or other medication to decrease salivation" (2/10/10); "due to excessive salivation, please consider restarting Cogentin or other medication to decrease salivation, if above change is not desired, please note rationale in chart, please obtain a new height measurement	

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		and send results to dietitian" (3/10/10); "please obtain a new height measurement and send to dietitian" (4/9/10); "please continue efforts to obtain a new height measurement and send results to dietitian" (5/5/10); and "please D/C [discontinue] order for ice cream at lunch" (6/2/10). It was of concern that recommendations were repeated from month to month without resolution. A new height measurement was requested to ensure dietary requirements were appropriate as "current height is listed as 66 inches and is questionable." The last PNMT (NMT) review, on 7/14/10, did not document that a new height measurement had been obtained. It was of concern that due to not having an accurate height measurement, his BMI score may be lower than reported and place him in a lower BMI risk category. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>A process is in place that identifies individuals with PNM concerns.</u> Based on policy review (State and Facility) and record review, a process that identified individuals with PNM concerns was not defined sufficiently, as illustrated by: ▪ In 0 of the 17 records reviewed (0%), there was documentation of risk identification levels based upon physical and nutritional history, current status, and/or specific criteria for guiding placement of individuals in specific risk levels. ▪ In 0 of the 17 records reviewed (0%), there was documentation of comprehensive assessment process leading to the development of measurable, functional outcomes for individuals at highest risk, which included analysis of discipline-specific assessments (OT, PT, SLP, nursing, medical, nutrition, psychology), PNMP Clinic results, PNM (NMT) Meeting Summary, and individual-specific consultations. ▪ In 0 of the 17 records reviewed (0%), there was documentation of development of implementation strategies. ▪ In 0 of the 17 records reviewed (0%), there was documentation of competency-based training for individual strategies. ▪ In 0 of the 17 records reviewed (0%), there was documentation of monitoring schedule for individuals at highest risk. ▪ In 0 of the 17 records reviewed (0%), there was documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. Examples of the lack of a sufficiently defined PNM process were: ▪ Individual #231 had a Body Mass Index score of 59, which placed her in the category of "super obesity." It was unclear why the PNMT (NMT) rated her at a Risk Level 2 – Moderate Risk, due to the significant health risks involved with	Noncompliance

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		her current overweight status. The PNMT (NMT) reviewed her five times from 10/21/09 to 7/28/10, with the following recommendations: continue oral eating, continue current diet and feeding techniques and "consider a Personal Support Team (PST) meeting with psychologist present to create additional strategies and better compliance for improved health." The status of this recommendation was not discussed in subsequent PNMT (NMT) reviews. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health, physical and nutritional support needs. ▪ Communicable Disease Report for Pneumonia (5/1/09 to 5/31/10) documented a diagnosis of pneumonia for Individual #348 on 2/7/10. He did not have a PNMP "at this time." His initial review by the PNMT (NMT) occurred on 3/10/10, and recommended "due to pneumonias in 1/09 and 2/10 please order an MBS to rule out aspiration and determine most appropriate food/liquid textures to prevent oral intake as contributor to pneumonia." The request for a MBS order continued in April and May 2010. In May 2010, the PNMT documented "if above recommendation (related to MBS) is deemed unnecessary or inappropriate at this time, please document rationale in integrated progress note." His Modified Barium Swallow study, dated 6/7/10, documented severe dysphagia, and placed him at risk for aspiration pneumonia. It was of concern that Individual #328 did not receive an MBS until approximately three months after the PNMT (NMT) recommended this study. In addition, the PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #353's PNMT (NMT) review on 3/31/10, documented "3/8/10 Stage II to Stage III decubitus bottom of L (left) foot and Stage III decubitus to buttocks." Stage II decubitus ulcers, or pressure sores, occur when the skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III pressure ulcers occur when the skin breakdown looks like a crater where there is damage to the tissue below the skin. (http://www.nlm.nih.gov/medlineplus/ency/article/007071.htm) It was recommended: "due to skin integrity issues, she would benefit from a wound healing supplement." The last review completed on 5/12/10, documented "hopeful that protein supplement will promote healing of skin integrity issues." The PSP Addendum, dated 8/5/10, documented the "PST met to discuss [her] weight loss and wound care recommendations." No further review by the PNMT was noted. Despite these serious, and largely preventable healthcare issues, the PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health, physical and nutritional support needs.	

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		▪ Individual #540's Physical Therapy Update, dated 6/3/10, documented frequent falls. Individual #540 had not been referred and/or reviewed by the PNMT (NMT). ▪ Individual #100's Modified Barium Swallow, dated 7/2/09, documented severe dysphagia. The Communicable Disease Report for Aspiration Pneumonia (5/1/09 to 5/31/10) documented a diagnosis of aspiration pneumonia for Individual #100 on 7/7/09. He also was admitted to the Infirmary on 7/21/10 with wheezing and vomiting. He was diagnosed with pneumonia and sepsis. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #409 was in the Infirmary during the on-site review with a diagnosis of pneumonia. The PNMT (NMT) review and recommendations log documented "scheduled to be seen 8/11/10 due to recent pneumonia." The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health, physical and nutritional support needs. ▪ Individual #511's NMT Review and Recommendations Log documented the following Infirmary admissions: o On 3/27/09, for anorexia, dehydration, and UTI; o On 4/28/09, for UTI, and anorexia; o On 8/4/09, for probable pneumonia; o On 8/6/09, ONO (over night observation) blood cultures show gram positive cocci; o On 12/31/09, for dehydration secondary to anorexia, and chest X-ray revealed early patchy lower left lung infiltrate; o On 3/28/10, ONO hypoxia, and diagnosis bronchitis; o On 5/17/10, ONO hypoxia, and diagnosis bronchial pneumonia; and o On 5/19/10, ONO for rehydration. Infirmary/ONO admissions on 3/28/10, 5/17/10, and 5/19/10, were not documented on the Infirmary/hospital admissions list submitted as part of the Monitoring Team's document request. The Communicable Disease Report for Pneumonia (5/1/09 to 5/31/10) documented diagnoses of pneumonia on 6/30/09, 12/23/09, and 5/18/10. The PNMT (NMT) reviews dated 7/21/10, 7/28/10 and 8/4/10 documented "currently in [hospital] with pneumonia. Will reschedule next week." The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. <u>Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the</u>	

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		course of the day and during nutritional intake by the PNM team. Review of 12 records involving individuals who had been identified by the Facility as being at high risk, including Individual #7, Individual #205, Individual #154, Individual #106, Individual #272, Individual #504, Individual #491, Individual #357, Individual #108, Individual #400, Individual #285, and Individual #386 revealed the following: ▪ In 0 of the 12 records reviewed (0%), there was documentation of PNM (NMT) review/analysis of the findings of relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary, addressing: o Physical health status; o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; o Positioning during the course of the day; and o Nutritional intake. ▪ In 0 of the 12 records reviewed (0%), measurable, functional outcomes were identified. ▪ In 0 of the 12 records reviewed (0%), there was documentation of PNMPs developed with input from the PNM (NMT) for those individuals at highest risk. ▪ In 0 of the 12 records reviewed, there was congruency between Strategies/Interventions/Recommendations contained in the PNMP, and the concerns identified in the comprehensive assessment. ▪ In 0 of the 12 records reviewed (0%), comprehensive summary results were integrated into the design of the appropriate PNM support plans as outlined in HCG VI and VIII and SA O-3 through O-8. ▪ In 0 of the 12 records reviewed (0%), PNM (NMT) updates were provided as needed until the individual was discharged from the PNM (NMT) Team. Examples of where the PNM (NMT) did not provide individuals with a comprehensive assessment/summary, integration of summary into the PNMP, and/or updates were: ▪ Individual #7 was identified at high risk for aspiration pneumonia and respiratory issues (ABSSLC All Inclusive Risk Listing). The Communicable Disease Report for Pneumonia (5/1/09 to 5/31/10) documented diagnoses of pneumonia on 2/28/10, and 4/24/10. The initial PNMT (NMT) review occurred on 3/31/10, one month after his diagnosis of pneumonia. He was reviewed three times after the initial review. The following recommendation was documented in the 7/14/10 review, which was over four months since his first diagnosed pneumonia: "NMT will request that he be seen in PNMP clinic to review positioning due to recurrent pneumonias." During this NMT review he	

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		was assigned a Risk Level 2 – Moderate Risk. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #205 was identified at high risk for constipation (ABSSLC All Inclusive Risk Listing). He received a Modified Barium Swallow (MBS) study on 7/16/09, which documented severe dysphagia necessitating texture modification for safe oral intake. There were recommendations to modify his diet texture and fluid consistency, position upright, use Sterident tooth brushing protocol and monitor closely for signs/symptoms of aspiration. Individual #205 did not have a PNMP "at this time." His initial review by the PNMT (NMT) was on 9/9/09, even though he had received an MBS in July 2009, which indicated significant physical and nutritional support needs. He was reviewed by the PNMT (NMT) for new MBS, vomiting, and weight. He was reviewed six additional times, but there was no discussion of his high-risk status for constipation. He continued to have issues with vomiting in all reviews. On 4/13/10, the NMT review recommended: "Please call PST with OT present to discuss the following: a) consider creating a variety of items safe for him to manipulate so that he is actively engaged, and b) also offer 6-8 oz. water when behavioral problems occur." There were no PSP Addendum(s) to address these recommendations. The PST met monthly from 2/10 to 7/10 to discuss his high-risk status for constipation. Each month the PSP Addendum stated "The team met and agreed that Individual #205 is a high health risk based on his chronic constipation and a history of recurrent vomiting. He has had 3 x-rays in the past 3 months which reveal fecal colon." The plan to reduce his risk level involved monitoring through a nursing care plan and taking medication for constipation. These strategies were not changed during the six months he was reviewed, and he continued to experience vomiting as documented in the PNMT (NMT) reviews. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #154 was identified at high risk for GI concerns (ABSSLC All Inclusive Risk Listing). The PNMT (NMT) reviewed him for an annual review on 9/9/09. He was reviewed subsequently eight times. The reviews documented the following Infirmary admissions: o On 2/24/09, with diagnoses of phenytoin and lithium toxicity, lower weight loss with lethargy, anorexia, and partial bowel obstruction; o On 5/19/09, for erosive esophagitis, duodenitis, ileus, Upper GI bleed, pressure sores, hyperkalemia, and hypoalbuminemia; o Discharged 9/29, vomiting probably secondary to constipation; o From 11/16/09 to 11/25/09, he went to the Infirmary and then the	

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		hospital from 11/16/09 to 11/20/09, with severe constipation, UGI (upper gastrointestinal) bleed, erosive esophagitis, and autral gastritis; o On 11/28/09, ONO and the hospital for hypoxia; o On 12/3/09, ONO with gastroparesis; o From 12/26/09 to 12/30/09, with recurrent gastroparesis and hypokalemia; o From 12/30/09 to 2/10/10, for skin breakdown on coccyx, held Reglan for three days to see if needed to prevent gastroparesis, plan to reduce anticholinergics medications due to possible overmedication to address behavior, vomiting due to constipation, ankle lesion noted, abdominal distention, and blood in stool with Hemoccult possibly due to anal fissure; o On 3/10/10, returned home after administrative assignment to Infirmary; o On 4/4/10, ONO for vomiting; and o On 4/19/10, ONO for EGD. Many of these Infirmary visits were not documented on the submitted Infirmary/ER/hospitalization list. The PNMT (NMT) reviewed Individual #154, but did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health, physical and nutritional support needs. ▪ Individual #106 was identified at high risk for osteoporosis (ABSSLC All Inclusive Risk Listing). Infirmary admitting diagnoses were staus/post (S/P) rod placement right tibia related to fall/seizure on 2/3/10; and post tibia fracture, intramedullary orf (hand infection), klebsiella cystitis (bladder infection), on 2/19/10. On 01/30/10, he had an admission to the ER with diagnosis of fracture "RLL". Individual #106 did not have a PNMP "at this time" per documentation submitted in the individual record requests. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address his complex health and physical support needs. ▪ Individual #504 was identified at high risk for weight (ABSSLC All Inclusive Risk Listing). Her BMI score was 42, which placed her in the morbid obesity range. Individual #504's PSP Addendum, dated 6/7/10, documented a choking incident on 6/5/10. The NMT documented the choking incident as "serious." A new MBS was completed on 6/17/10, and recommended: "due to poor esophageal motility noted during this study, she may benefit from further testing such as a UGI [Upper Gastrointestinal] or manometry study to further investigate these issues and possible need for intervention." Her last PNMT (NMT) review on 07/14/10, recommendations were to continue oral eating, and current diet and feeding techniques. Her Risk Level changed from 2 (Moderate) to 1 (High)	

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		across multiple reviews. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health and physical support needs. ▪ Individual #357 was identified at high risk for weight (ABSSLC All Inclusive Risk Listing). Her Nutrition Assessment, dated 4/22/10) documented her "BMI score as 33.8, which indicates obesity." The document entitled "Individuals with BMI equal to or greater than 30" did not identify Individual #357 as having a BMI score greater than 30. The Communicable Disease Report for Aspiration Pneumonia documented a diagnosis of aspiration pneumonia for Individual #357, on 5/21/10. There were two admissions to the Infirmary and the community hospital during May 2010. Her initial review by the PNMT (NMT) was 5/26/10 with the reason for follow-up identified as colon resection, malignant hyperthermia, and pneumonia. Her recommendations were to continue oral eating, current diet and feeding techniques. The PNMT (NMT) did not complete a timely and proactive comprehensive assessment leading to the development of strategies to address her complex health and physical support needs.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> Based on a review of a sample of 29 individual records (Individual #241, Individual #148, Individual #503, Individual #208, Individual #8, Individual #231, Individual #289, Individual #145, Individual #348, Individual #353, Individual #540, Individual #100, Individual #409, Individual #511, Individual #65, Individual #464,Individual #457, Individual #7, Individual #205, Individual #154, Individual #106, Individual #272, Individual #504, Individual #491, Individual #357, Individual #108, Individual #400, Individual #285, and Individual #386) individuals were not provided consistently with a comprehensive PNMP. Although a number of the components of a comprehensive PNMP were present for many individuals, there were a number of components missing. More specifically: ▪ In 20 of 29 records reviewed (69%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 20 of 29 records reviewed (69%), transfer instructions were included. ▪ In 20 of 29 records reviewed (69%), the mealtime/dining plan included oral intake strategies for mealtime and snacks. ▪ In 20 of 29 records reviewed (69%), the mealtime/dining plan included food/fluid texture. ▪ In 20 of 29 records reviewed (69%), the mealtime/dining plan included behavioral concerns related to intake. ▪ In 18 of 29 records reviewed (62%), strategies for medication administration were included.	Noncompliance

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		▪ In 17 of 29 records reviewed (59%), strategies for oral hygiene were included. ▪ In 20 of 29 records reviewed (69%), individual adaptive equipment was included. ▪ In 0 of 29 records reviewed (0%), bathing/showering positioning and instructions were included. ▪ In 20 of 29 records reviewed (69%), personal care instructions were included. ▪ In 20 of 29 records reviewed (69%), communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ The following nine individuals were identified at high risk, but did not have a PNMP: Individual #8 who sustained a fracture; Individual #231 who had a BMI Score of 59, which placed her in the super obesity category; Individual #348 who had a MBS that documented severe dysphagia; Individual #205 who ABSSLC identified at high risk for constipation; Individual #106 who ABSSLC identified as being at high risk for osteoporosis; Individual #357 who ABSSLC identified as at high risk for weight; Individual #285 who ABSSLC identified as at high risk for GI concerns; Individual #491 who ABSSLC identified as being at high risk for GI concerns and weight; and Individual #272 who ABSSLC identified as being at high risk for GI concerns. ▪ PNMPs need to incorporate strategies for medication administration, bathing/showering and/or oral care for those individuals identified at risk. In addition, these PNMP strategies need to be integrated with an individual's nursing care plan. Per report, ABSSLC's QMRPs were responsible for completing a Special Considerations document. Currently, there was not a policy providing criteria for the development of this document. The Special Consideration document contained information from the PNMP and/or presented information that was in conflict with the PNMP, which could result in staff confusion as to which document had the correct strategies. The Facility should review the purpose of this document and ensure that if information provided about the PNMP is included in the Special Considerations document that such information is current. PNMPs were revised on a frequent basis, which would require the Special Consideration document to be revised as well. <u>PNM plans were incorporated into individual's Personal Support Plans.</u> In 0 of 10 records reviewed (0%) (Individual #7, Individual #154, Individual #504, Individual #108, Individual #400, Individual #386, Individual #289, Individual #241, Individual #148, and Individual #100) were PNMPs incorporated into individual Personal Support Plans. They were simply referenced or listed. Examples of where individual PNMPs were not incorporated in PSPs included:	

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		▪ Individual #7 had complex health, physical and nutritional support needs Individual #7's PSP under the Occupational Therapy/Physical Therapy Evaluation stated "continue PNMP to provide appropriate support through seating, preventing skin breakdown, ensuring appropriate nutrition/hydration by managing recurrent pneumonias with positioning, and monitoring G-tube tolerance," but his PNMP strategies were not integrated across all disciplines within his PSP. ▪ Individual #154 was identified by ABSSLC at high risk for skin integrity. His PSP, dated 10/14/09, did not integrate his PNMP strategies into his annual plan. ▪ Individual #504 was identified by ABSSLC at high risk for weight. Her PSP, dated 12/1/09, did not integrate her PNMP strategies across all disciplines in her annual plan. ▪ Individual #108 was identified by ABSSLC at high risk for GI concerns. Her PSP, dated 2/3/10, did not integrate her PNMP strategies across all disciplines in her annual plan. <u>PNMPs are developed with input from the IDT, home staff, medical and nursing staff.</u> Of the 10 records reviewed (Individual #7, Individual #154, Individual #504, Individual #108, Individual #400, Individual #386, Individual #289, Individual #241, Individual #148, and Individual #100), one (Individual #154) of the PNMPs (10%) was developed with input from the IDT with an emphasis the inclusion of direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Individual #7's PSP, dated 8/4/10, documented "PNMP was reviewed and remains accurate." There was no OT, SLP, or physician in attendance at the team meeting. ▪ Individual #505's PNMP was not reviewed and approved during her PSP, on 12/1/09. ▪ Individual #108's PSP, dated 2/3/10, documented the review of her PNMP, but neither home staff nor therapists (OT, PT, and/or SLP) were in attendance. ▪ Individual #400's PSP, dated 1/14/10, documented "no changes recommended at this time" for his PNMP, but it could not be determined who attended the meeting, because the signature page was blank. ▪ Individual #386's PSP, dated 5/4/10, documented a change in diet, but did not document approval of the PNMP. Home staff and therapists (OT, PT, and SLP) did not attend the PSP. ▪ Individual #289's PSP, dated 8/13/09, documented "no changes or additions needed at this time," but there were no therapists (OT, PT, SLP) in attendance. ▪ Individual #241's PSP, dated 8/4/09, did not discuss her PNMP. No therapists	

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		(OT, PT and SLP) were in attendance. ▪ Individual #148's PSP, dated 3/9/10, documented team approval of the PNMP, but there was no signature sheet to determine the composition of the PST. ▪ Individual #100's PSP, dated 9/16/09, documented "review PNMP for accuracy/changes. Will review with the team. Changes will be implemented by the PT." There was no further discussion related to the PNMT. A physical therapist was in attendance, but no OT or SLP. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed.</u> Of the 10 records reviewed (Individual #7, Individual #154, Individual #504, Individual #108, Individual #400, Individual #386, Individual #289, Individual #241, Individual #148, and Individual #100), one (10%) of the PNMPs was reviewed annually at the PSP meeting, and updated as needed. Examples of where individual PNMPs were not developed with input from the IDT included: ▪ Refer to examples above. <u>PNMPs are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results.</u> In 0 of 9 records reviewed (Individual #348, Individual #231, Individual #8, Individual #272, Individual #491, Individual #285, Individual #357, Individual #106, and Individual #205) (0%), PNMPs were developed**,** reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> Forty-nine observations were completed of staff's implementation of dining plans and/or PNMPs. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMPs and/or mealtime plans. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration, or other risks, such as skin breakdown, risks due to falls, etc. The following provides additional details regarding the observations: ▪ In 11 of 34 observations (32%), staff were following mealtime plans. ▪ In 2 of 8 observations (25%), staff were following wheelchair positioning instructions. ▪ In 0 of 1 observations (0%), staff were following alternate positioning instructions. ▪ In 3 of 3 observations (100%), staff were following transfer instructions, ▪ In 0 of 3 observations (0%), nursing staff were following mealtime instructions for medication administration.	Noncompliance

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		Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: ▪ A PNMP coordinator was present during observations of medication administration and dinner. These observations documented errors in positioning and use of adaptive equipment during medication administration, as well as errors in positioning and correct diet texture during the dinner meal. The PNMP Coordinator did not provide coaching/mentoring to staff to correct these errors. The Monitoring Team asked the PNMP Coordinator about incorrect diet texture for an individual and when prompted, he worked with staff to correct the error. PNMP Coordinators were responsible for providing support in the dining rooms as well as completing mealtime monitoring. Per this observation, therapy staff should review the training that was provided to PNMP Coordinators, as well as conduct frequent onsite reviews to ensure PNMP Coordinators have the skills to provide coaching/mentoring, as well as to conduct monitoring. Per report (informational document submitted by Lead OT in document request dated 8/8/10), the Lead OT was a member of a statewide group meeting to standardize PNMP Coordinator training statewide. The expectation was PNMP Coordinator standardized training would be in place during the next on-site visit. ▪ The nurse in 5962 had PNMPs attached to the Medication Administration Record (MAR), which was positive. However, there were errors observed during medication administration such as individuals in poor alignment and support. Additional support/training will be needed for nurses to ensure competence to implement PNMP strategies.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> Review of the Facility's training curricula revealed that it did include adequate PNM training in the following areas: ▪ Body mechanics; ▪ Handling techniques; ▪ Optimal alignment and support in seating systems and alternate positions; ▪ Mechanical lift transfers; ▪ Manual transfers approved by facility policy; ▪ Mealtime positioning; ▪ Food and fluid consistency; ▪ Safe presentation techniques for food and fluid; and ▪ PNMPs. <u>Competency-based training focuses on the acquisition of skills or knowledge and is</u>	Noncompliance

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		represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable. Based on a review of 29 individual records, there was no staff competency-based training record documentation (0%) to document that staff completed the following: ▪ In 0 of 29 individual records (0%), were there staff training records to document staff completed pre/post tests for information-based learning. The Monitoring Team requested competency-based staff training documentation for 29 individuals, but no documentation was submitted. There were PNMP training rosters submitted for staff training, but the forms did not document staff demonstration of competency, nor did the form have a competency checklist for what was being trained such as the PNMP All foundational trainings are updated annually. Based on a review of staff development training schedules, staff training records and facility training reports foundational trainings were not scheduled annually. Based on information provided by the Facility, it was reported from 6/09 to 6/10, 622 of 1192 staff (52%) of ABSSLC staff were provided foundational training. Staff are provided individual-specific training of the PNMP by the appropriately trained personnel. Based on a review of staff PNMP training records documented competency-based person-specific training was not provided by appropriately trained personnel. This was illustrated as follows: o In 0 of 29 records reviewed (0%), PNMP coordinators had been provided instruction by licensed therapists and/or assistants. o In 0 of 29 records reviewed (0%), licensed therapists, assistants and/or PNMP coordinators had trained supervisors and/or other designated staff who would be responsible for implementation of PNMPs. o In 0 of 29 records reviewed (0%), licensed therapists, assistants, PNMP coordinators and/or competency-trained designated supervisors/home managers, etc. had provided instruction to direct support professionals. PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual. In 0 of 29 individual records reviewed, was there documentation that staff who provided assistance to individuals determined to be at an increased level of risk had successfully completed competency-based training. Staff are trained prior to working with individuals and retrained as changes occur with	

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		the PNMP. Based on a review of 29 staff training in individual records, 0 out of 29 (0%) showed that staff were re-trained when changes occurred on the PNMP. Examples of staff not being retrained on revised PNMPs included: • Individual #504's PNMP was revised on 6/23/10, but the PNMP did not identify what was revised. There was no documentation that staff had been re-trained for these revisions. • Individual #154's PNMP was revised on 4/6/10, but there was no training records to document that staff had been re-trained on the revisions.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. Based on review of the Facility's policy, ABSSLC did not have an adequate policy defining the monitoring system for PNMPs. Such a policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans. At a minimum, such a policy should include: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; ▪ Identification of monitors and their roles and responsibilities; ▪ Formal schedule for homes to be monitored on a quarterly basis, with an identified staff schedule; ▪ A re-validation of monitors on an annual basis by therapists and/or assistants; and ▪ Results of monitoring activities in which deficiencies noted are formally shared for appropriate follow-up by the relevant supervisor. As stated in the baseline report, the Physical and Nutritional Management Policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs were not being implemented as written. There were no revisions to this policy, nor did the Facility's POI address changes to monitoring. The Facility presented the following tools to be used to monitor implementation of PNM procedures and plans: ▪ PNMP Training Form, which had 16 areas of competency; ▪ Sensory Diet Training Form, which had 11 areas of competency; ▪ ABSSLC State School Mealtime Observation, which had 23 observation questions; ▪ PNMP Monitoring Form-Routine, which had 16 questions to be answered by	Noncompliance

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		staff; ▪ Sterident Monitoring Log with the following instructions: "Home Program Technicians III will observe 6-2 shift one time per month and 2-10 shift one time per month. Any concerns should be stated on the back along with action taken;" ▪ Wheelchair Check Sheet; and ▪ Habilitation Therapy Wheelchair/Equipment Log. <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).</u> A review 29 individuals' records illustrated that 16 individuals' staff (55%) were being monitored, but the monitoring did not encompass all aspects in which the individual was determined to be at increased risk. The following concerns were noted: ▪ The PNMP monitoring form did not include positioning during oral hygiene, medication administration, and/or bathing/showering. ▪ A review of the PNMP Monitoring forms showed that "no" had been marked for the following indicators: staff initials were on the PNMP document sheet; PNMP was present; all assistive equipment was available, clean and in good working condition; and care provider was following schedules on the PNMP. The following indicators were marked "yes" on all of the monitoring forms reviewed: photos and equipment matched, individuals were well positioned, individuals were in optimal position for eating and were repositioned before meals, food texture was correct, feeding techniques/instructions were read AND followed, thickener was used for food and/or fluids, and individuals were monitored for pace and bite size. The Monitoring Team questions the validity of these monitoring results, because during multiple observations during the on-site review, staff did not demonstrate 100 percent competency with the preceding indicators. ▪ Individual #145's PNMP Monitoring Form-Routine documented yes/no for the indicator "care provider's initials are on the PNMP document sheet." It was unclear why an indicator would be marked yes/no, and there were no instructions for completion on the form. In addition, it was also unclear why the presence of staff initials on the PNMP form was considered a competency indicator. Competency/Demonstration would be circled on the form for yes and no answers. There were no instructions submitted for the completion of this form. Indicator #6 was "Care Provider is following schedules on the PNMP. If not explain in section at bottom of page." This indicator was marked "no" with no further explanation. Examples of PNM activities that were not being monitored: ▪ The following 13 individuals had not received PNM monitoring: Individual #241, Individual #8, Individual #231, Individual #289, Individual #348, Individual	

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		#409, Individual #205, Individual #106, Individual #357, Individual #285, Individual 108, Individual #491, and Individual #272. <u>All members of the PNM team conduct monitoring.</u> Based on the record review of 29 individuals, for none (0%) had the PNM (NMT) Team completed the following: ▪ In 0 of 29 records reviewed (0%), PNM (NMT) Team members completed individual-specific monitoring ▪ In 0 of 29 records reviewed (0%), monitoring was conducted on a frequent basis for those individuals at highest risk to ensure comprehensive summary strategies were implemented ▪ In 0 of 29 records reviewed (0%), deficiencies were noted during monitoring were corrected within an appropriate period of time ▪ In 0 of 29 records reviewed (0%), issues noted during monitoring were followed by the PNM team, and remained open until all issues have been resolved and appropriate trainings conducted ▪ In 0 of 29 records reviewed (0%), results of monitoring activities in which deficiencies were noted were formally shared for appropriate follow-up by the relevant supervisor. <u>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.</u> A review of Facility reports, including those from Quality Improvement/Quality Enhancement, HST minutes, and Mortality Review Committee did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM (NMT) for analysis leading to the identification and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. In addition, PNMT members should be actively involved in internal mortality reviews as a learning process as well as a mechanism for improving supports to individuals with the most complex health, physical and nutritional support needs. The PNMT (NMT) did meet on a regular basis as stated above with regard to Section O.1 of the SA. NMT meeting documentation submitted reflected a review of a significant number of individuals who were not identified at high risk. There was no documentation to support submission and review of Facility reports, such as Quality	

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		Improvement/Enhancement reports, HST minutes, and Mortality Review Committee reports. Such a review should have included analysis of the data, leading to the provision of enhanced supports to individuals with the most complex physical and nutritional support needs, and the provision of training and technical assistance to the Personal Support Teams who support them. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Based on review of nine individuals' records, the following examples illustrated that immediate intervention was not provided even when an individual was determined to be at risk of harm: ▪ The following nine individuals were identified at high risk but did not have a PNMP: Individual #8 who sustained a fracture; Individual #231 who had a BMI Score of 59, which placed her in the super obesity category; Individual #348 who had a MBS that documented severe dysphagia; Individual #205 who ABSSLC identified at high risk for constipation; Individual #106 who ABSSLC identified as being at high risk for osteoporosis; Individual #357 who ABSSLC identified as at high risk for weight; Individual #285 who ABSSLC identified as at high risk for GI concerns; Individual #491 who ABSSLC identified as being at high risk for GI concerns and weight; and Individual #272 who ABSSLC identified as being at high risk for GI concerns. Based on a review of six individuals who were deceased (Individual #161, Individual #249, Individual #419, Individual #90, Individual #475, and Individual #175), the following examples illustrated that immediate intervention was not provided even when an individual was determined to be at risk of harm: ▪ Individual #90 was diagnosed with: o Aspiration pneumonia on 12/23/09 (Communicable Disease Report 5/1/09 to 5/31/10); o Pneumonia on 2/24/10 (Communicable Disease Report 5/1/09 to 5/31/10); o Aspiration pneumonia on 3/21/10 (Communicable Disease Report 5/1/09 to 5/31/10); and o Aspiration pneumonia on 3/24/10 (Avatar Pneumonia Tracking). Her initial review by the PNMT (NMT) was on 2/5/10. The "reason for follow-up: annual enteral feeding review." There was documentation of her hospitalization for aspiration pneumonia from 12/23 to 12/26/09. The discussion documented: "Weight stable within RWR. Recent pneumonia is cause for concern. Enteral feeding remains the most appropriate means for provision of nutrition due to her history of aspiration and recent aspiration pneumonia. Current formula administration schedule is the least restrictive and provides her rest periods from pump feeding." The PNMT's (NMT) recommendations were: "oral eating is not recommended, continue enteral feedings and	

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		current formula." The next scheduled PNMT (NMT) review was 4/9/10, but she died on 4/8/10. Individual #90 was at significant risk of harm prior to her death. Individual #90 needed the expertise of a PNMT to provide an intensive, interdisciplinary problem-solving approach to initiate a comprehensive assessment leading to the development of strategies to minimize her significant health risks as evidenced by recurrent episodes of aspiration pneumonia. ▪ Individual #161 died on 7/25/09 due to shock, pneumonitis due to inhalation of food or vomitus, hypotension, acute renal failure. The PNMT (NMT) reviewed him six times but did not complete a comprehensive assessment. ▪ Individual #249's immediate cause of death was aspiration pneumonia. He was "scheduled for an initial NMT Review and Recommendations on 7/29/09 but he was in the hospital at the time and the review could not be completed." He died on 8/5/09. ▪ Individual #419's Consultation Report, dated 7/3/09, requested an MBS due to frequent coughing during meals, history of recurrent pneumonias, and weight loss. Individual #419's MBS, dated 8/3/09, documented that the individual was "at risk for aspiration. Monitor closely for signs/symptoms of aspiration." It was unclear why it took a month to have this procedure completed. The last review by the PNMT (NMT) was on 9/2/09 with the recommendations: continue oral eating and current diet and feeding techniques. Individual #419 died of acute respiratory failure, on October 3, 2009. ▪ For the reviews on 12/14/09, 12/16/09, 3/24/10, 3/31/10, 4/9/10, 4/13/10, 4/16/10, and 4/28/10, Individual #475's NMT Review and Recommendations Log documented that charts were not available and/or the individual was in Infirmary and/or hospital. He died on April 24, 2010. ▪ Individual #175 died on 5/15/10. The cause of death was respiratory failure and pneumonia. Individual #175's NMT Progress Note Log documented four reviews on 6/1/09, 12/14/09, 1/20/10 and 3/24/10. The recommendations were to continue oral eating and current diet and feeding techniques. On 12/14/09, an additional recommendation stated: "1) consider a TSH [thyroid stimulating hormone] test to address issues with hypothermia, hypotension and weight; 2) change Ensure w/meals to Ensure Plus w/meals; and 3) Please write orders for Snacks TID and Milkshakes TID." These recommendations did not comprehensively address strategies for his identified health risk concerns. The PNMT (NMT) reviewed these six individuals, but as stated in the baseline report, these reviews consisted of a chart review leading to recommendations that were generic in nature. The PNMT (NMT) did not provide an intensive, interdisciplinary problem-solving approach for these individuals with complex health, physical and nutritional support needs.	

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		A review of individuals who had died within the time period of July 2009 to June 2010 identified 10 individuals' causes of death as respiratory failure, pneumonitis due to inhalation of food or vomitus, acute respiratory failure, or pneumonia. There were an additional three individuals awaiting a death certificate to document the cause of death. An extensive, critical review of the mortality reports, including recommendations, by the PNS Team would be an important learning strategy to identify future person-specific strategies and systemic changes that could be employed to minimize the risk of harm for individuals with physical and nutritional support needs but, most importantly, for individuals at the highest health risk levels.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> Based on the review 29 individual records, in none of these cases (0%) did the PNM (NMT) Team complete a comprehensive assessment leading to the development of strategies, and as a result the PNMT (NMT) did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. In 0 out of 29 cases (0%) was documentation found to support that if strategies were not effective, strategies and PNMPs were revised. The following individuals did not receive review of their progress by the PNMT (NMT): Individual #241, Individual #148, Individual #503, Individual #208, Individual #8, Individual #231, Individual #289, Individual #145, Individual #348, Individual #353, Individual #540, Individual #100, Individual #409, Individual #511, Individual #65, Individual #464, Individual #457, Individual #7, Individual #205, Individual #154, Individual #106, Individual #272, Individuals #504, Individual #491, and Individual #357, Individual #108, Individual #400, Individual #285, and Individual #386. Examples have been provided throughout this report in relation to Section O of the SA. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u> Based on the review of 29 individual records, in none (0%) did the PNMT document the progress of individuals with PNM needs on a quarterly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators. In none of the 29 records reviewed (0%) was it documented that if PNMPs were found through this monitoring not to be effective, the PNMPs were updated.	Noncompliance
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Based on the review of 12 individual records (Individual #85, Individual #296, Individual	Noncompliance

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	months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	#362, Individual #77, Individual #257, Individual #435, Individual #431, Individual #70, Individuals #489, Individual #49, Individual #101, and Individual #512) who were enterally nourished, none (0%) of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO (by mouth) status. Examples of individuals who received enteral nutrition and did not receive an annual assessment included: ▪ Individual #296 received a PEG (percutaneous endoscopic gastrostomy) on 11/12/2008 (ABSSLC Individuals with G-Tubes 7/13/10). She did not receive an annual assessment (Nursing and/or OT/PT) that addressed the medical necessity of the tube and/or potential pathways PO (by mouth) status. ▪ Individual #362's OT/PT Annual Evaluation, dated 4/22/10, presented a historical perspective, but did not provide an assessment to determine the current medical necessity of the tube and potential pathways to PO status. ▪ Individual #77 received a PEG (percutaneous endoscopic gastrostomy) on 5/7/2008 (ABSSLC Individuals with G-Tubes 7/13/10). She did not receive an annual assessment (Nursing and/or OT/PT) that addressed the medical necessity of the tube and/or potential pathways PO (by mouth) status. ▪ Individual #257 received a gastrostomy tube on 6/6/03 (ABSSLC Individuals with G-Tubes 7/13/10), but no annual assessment was found. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above with regard to Section O.3 of the SA.</u> Based on a review of the 12 individuals' PNMPs, none of the individuals (0%) who received enteral nutrition and/or therapeutic/pleasure feedings were provided with PNMPs that incorporated the components listed in section O.3 above. Examples of individuals who received enteral nutrition but were not provided with a comprehensive PNMP included: ▪ Individual #85's OT/SLP Eating Evaluation Nutritional Management Plan, dated 7/2/10, included recommendations as follows: "NPO-all nutrition/hydration via G-tube, discontinue all adaptive eating equipment, no oral gustatory stimulation program provided or recommended due to progressive dementia and refusal of oral intake, elevate head of bed/wheelchair at all times and optimal oral intake position is most upright position of wheelchair for feedings, oral hygiene and medication administration." These recommendations had not been incorporated into her PNMP that was last revised on 2/5/10. ▪ None of the 12 individuals' PNMPs incorporated bathing/showering	

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		instructions. ▪ Four of the 12 individuals' PNMPs (33%) did not provide medication administration instructions. <u>The need for continued enteral nutrition is integrated into the PSP.</u> Based on a review of the 12 records, of 1 (Individual #49) of 12 individuals' PSPs (8%) who received enteral nutrition clearly documented the rationale for the continued need for enteral nutrition. Examples of individual PSPs that did not document the rationale for the continued need for enteral nutrition were: ▪ Individual #512's PSP, dated 1/21/10, documented he was "NPO except for recreational drinking of warm liquids thickened to thick milkshake consistency." His gastrostomy tube was placed on 3/22/01. His most current OT/PT evaluation was on 5/29/01, and most recent OT/SLP Eating Evaluation/Nutritional Management Plan Addendum was on 2/8/05. The PSP did not clearly document the rationale for the continued need for enteral nutrition. ▪ Individual #101's gastrostomy tube was placed on 10/17/91. Her Eating Evaluation/Nutritional Management Plan, dated 4/12/04, documented "recreational eating sessions twice a day." She participated in a recreational eating at 10 a.m. and 3 p.m. Her most current OT/PT evaluation was dated 4/26/04. Her PSP, dated 3/8/10, did not clearly document the rationale for the continued need for enteral nutrition. ▪ Individual #498 received her PEG tube in November 2007. Individual #489's PSP, dated 5/5/10, did not document the rationale for the continued need for enteral nutrition. <u>When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used.</u> Based on a review of five of five individual records (100%) who have been determined that it was appropriate for them to return to oral feeding, a plan was in place that addressed the process to be used. <u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u> Facility policies including Nursing Services: Management of Transabdominal Feedings, revised 4/7/10; Physical Nutritional Management, implemented 1/31/10; and Nutritional Management Team, implemented 1/31/10, did not clearly define the frequency and depth of evaluations related to an individual receiving enteral nutrition.	

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		<u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.</u> Based on a review of one of one individual record (0%) for Individual #85 who recently received and/or were at risk of receiving a feeding tube, showed the individual did not receive the following: ▪ In 0 of 1 record reviewed, the individual was referred to the PNM (NMT) for review and the development of a comprehensive assessment/summary. ▪ In 0 of 1 record reviewed, the individual received interventions to promote continued intake. ▪ In 0 of 1 record reviewed, monitoring was completed by the PNM (NMT) Team to support the efficacy of the interventions. Examples of individuals who did not receive these interventions prior to the placement of a feeding tube were: ▪ Individual #85 received a PEG (percutaneous endoscopic gastrostomy) tube on 2/17/10 due to an ongoing problem with dehydration and anorexia (OT/SLP Eating Evaluation Nutritional Management Plan 7/2/10). The PNMT (NMT) reviewed Individual #85 four times prior to the placement of her PEG tube, on 9/9/09, 10/14/09, 11/10/09, and 2/10/10. The PNMT (NMT) was not able to review her on 3/12/10 reportedly because she was "currently in INF. Charts not available. Will reschedule." The NMT reviewed her on 3/24/10 and documented: "Weight well within RWR. Tolerating G-tube feedings well." The PNMT (NMT) did not complete a comprehensive assessment to develop strategies to promote continued oral intake prior to the placement of a feeding tube.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The PNMT membership should include the expertise of a physical therapist. Ancillary members should be actively involved in the PNMT process, when appropriate.
2. Additional opportunities should be provided for continuing education for all PNMT members, not just therapists, to support their responsibilities in working with individuals with complex physical and nutritional support needs.
3. In order for a dedicated PNM team to carry out the full responsibilities of a properly functioning team, there will be a substantial increase in the caseloads of the remaining therapists and dietitians. The Facility should complete an analysis to determine the number of therapy and nutrition positions necessary to support these professionals being active members of individuals' PSTs.
4. Individuals identified with complex physical and nutritional support needs should have a timely, proactive comprehensive assessment completed; an appropriate PNMP developed and implemented; regular review, documentation, monitoring and analysis to determine the efficacy of the supports provided; and modifications to plans, as necessary.
5. Criteria should be defined for referral of individuals to the PNMT. Individuals at highest risk should be prioritized to receive a PNMT

comprehensive assessment. Upon completion of the comprehensive assessment/summary the PNMT should develop and implement intervention plans, conduct individual-specific monitoring, develop and implement documentation guidelines, and complete a review and analysis to determine the efficacy of supports provided at both the individual-specific and systemic level(s).

6. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
7. The Facility should review the purpose of the Special Considerations document and ensure that if information provided about the PNMP is included in it that such information is current. PNMPs are revised on a frequent basis, which would require the Special Considerations document to be revised often as well.
8. The Facility's therapy staff should review the training that was provided to PNMP Coordinators, as well as conduct frequent onsite reviews to ensure PNMP Coordinators have the skills to provide coaching/mentoring, as well as to conduct monitoring.
9. PNMT members should be actively involved in internal mortality reviews, as a learning process as well as an opportunity for improving supports to individuals with the most complex health, physical and nutritional support needs.
10. The monitoring policy should describe a monitoring system that includes criteria for and identification of who will complete the monitoring, competency-based training for monitors, description of each indicator with monitoring strategy, definition of staff re-training thresholds, a validation/inter-rater reliability process, the use of monitoring reports to assist in the identification of problematic issues and/or trends, the formulation of corrective strategies to address areas of deficiency, and integration of the monitoring system into facility Risk Management and Quality Improvement systems.
11. All policies related to mealtime and PNMP monitoring should be reviewed to ensure identified performance indicators are effective in monitoring mealtimes, as well as to ensure continued staff competency with regard to knowledge and skills acquired in competency-based physical and nutritional support foundational training. Such policies need to define "regular" monitoring as required by the Settlement Agreement. In addition, policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed to ensure adequate monitoring as required by the SA and HCG.
12. Procedures should be developed and implemented to ensure individuals at risk of receiving enteral nutrition are referred to the PNMT.
13. Comprehensive evaluation should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving enteral nutrition, and, if not, to identify strategies to transition an individual to oral intake, if appropriate. This will require assessment/evaluation by a number of team members, and review by the entire PST.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Wheelchair List, dated 7/12/10; o Chart listing multiple individuals with Adaptive Equipment, not dated; o Decubitus Reports, 8/09 through 6/10; o List of individuals who experienced a Falling Incident, 4/10 through 7/10; o Maintenance log to track orders/modifications to Adaptive/Assistive Equipment, 9/09 through 7/10; o Assessments including: Seating System Assessment (blank), not dated; Berg Balance test/evaluation (blank), dated 11/03; PT bicycle assessment/evaluation (blank), dated 4/04; Cratty Perceptual Motor test/evaluation (blank), dated 11/03; Performance oriented assessment of Balance and Gait (blank), dated 11/03; o Seating System Assessment for multiple individuals, dated 6/09 through 6/10; o OT/PT Annual evaluation for multiple individuals, 11/09 through 4/10; o PT Update for multiple individuals, 11/09 through 6/10; o Orthotics work orders for multiple individuals, 1/09 through 7/10; o Habilitation Therapy/Wheelchair Log for multiple individuals, 3/10 through 6/10; o PNMP Clinic for multiple individuals, 1/10 through 6/10; o Adaptive Eating Equipment and Positioning for multiple individuals, dated 1/20/10; o Chart listing multiple individuals with Adaptive Equipment/Programming, not dated; o Master Program list, dated 7/5/10 and 7/14/10; o Consultation Tracker, dated 7/10; o Revision PNMP tracking, 5/10 through 7/10; o Dining Plan roster, dated 7/13/10; o List of individuals with Wheelchairs, dated 7/12/10; o OT/PT Center Programs, not dated; o Sensory Gym Tracker, not dated; o PNMP Training form for multiple individuals, dated 6/10; o Adaptive Equipment Program Review Objective Data sheet for multiple individuals, dated 5/10 and 6/10; o PNMP Monitoring form-Routine, dated 6/10 and 7/10; o Mealtime Observation, dated 6/10; o Presentation Book Section P; o The following documents as requested and provided: OT/PT Assessment, OT/PT Updates, Wheelchair Assessment, OT/PT Service Plans with goals and objectives; OT/PT Programs with goals/objectives, OT/PT consultations for past year, Dining plan/diet card, PNMP (current and revised) for past year, PNMP Clinic notes for past year, PNMP Monitoring for June through July 2010, Staff competency-based training documentation for PNMP and OT/PT programs, and OT/PT monthly/quarterly progress notes for the following

	individuals: Individual #254, Individual #337, Individual #21, Individual #232, Individual #447, Individual #401, Individual #431, Individual #206, Individual #377, Individual #118, Individual #73, Individual #100, Individual #478, Individual #58, Individual #219, and Individual #396 ▪ **Interviews with**: o Glen Funky, Physical Therapist (PT), Director of Habilitation Therapy; o Karen Mayfield, Lead PT; o Bobbie Holden, Lead Occupational Therapist (OT), NMT Member; and o PNMP Coordinators and Home Program Technicians ▪ **Observations of**: o Observations in homes 5961, 5962, 5971, 5972, 6330, 6460, 6450, 6700, 6690, 6521, 6350, 5972, 6500, 6370, and 6480; o Observations in Vocational and Activity Centers; o Observations in Habilitation Therapy
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for ABSSLC did not include this component, the POI for Section P identified compliance and/or non-compliance with identified indicators. ABSSLC's POI indicated the Facility was in compliance with some of the indicators in Section P. However, based on the Monitoring Team's review, the Facility was not in compliance with the requirements of the SA. Status of compliance for each of the Settlement Agreement requirements, including individual examples supporting the determination of non-compliance are provided below. Examples of indicators that the Facility rated as being in compliance, but noncompliance was documented by the Monitoring Team included: The POI documented compliance with the indicator P.1.4 that requires that all individuals receive a comprehensive integrated Occupational Therapy/Physical Therapy assessment upon admission. OT/PT evaluations requested for new admissions did not document these assessments contained the necessary elements. The POI for Section P.1.6 documented compliance with identified components of the comprehensive OT/PT assessment (functional and wheeled mobility, gait analysis and other physical findings as indicated). These components had not been memorialized within policy, and there was not documentation submitted to substantiate that 100% of records reviewed contained assessments with these components. The POI for Section P.1.9 documented compliance for the indicator that required that individuals who had changes in status or a Personal Support Team referral received a subsequent comprehensive assessment. The Monitoring Team cited multiple examples within Section O and P when an individual had had a change in status without the completion of a comprehensive OT/PT assessment. The POI for Section P.2.7 documented compliance for the indicator that read: "on at least a monthly basis or more often as needed, the individual's OT/PT status was reviewed and plans updated as indicated by a

	change in the person's status, transition (change in setting) or as dictated by monitoring results." The Monitoring Team did not find evidence to support compliance. The POI for Section P.3.2 documented compliance for staff completion of general and person-specific competency-based training related to the implementation of OT/PT recommendations. The Monitoring Team's observations did not support compliance with staff competency in implementing OT/PT recommendations, nor did the training documentation document staff demonstration of the necessary skills. The POI for Section P.4.4 documented compliance for staff being monitoring for their continued compliance in implementing OT/PT programs. The Monitoring Team's observation and record review did not support compliance with this indicator.
	Summary of Monitor's Assessment: There were 452 individuals living at ABSSLC. The current caseloads for occupational and physical therapists were too large allow therapists to be active members of the individuals' PSTs, and were presenting significant challenges in meeting the standards set forth in the SA and Health Care Guidelines (HCG). At the time of the review, there were six budgeted positions for Occupational Therapy, with three vacancies. There were five Physical Therapy budgeted positions, with no vacancies. None of the OT/PT evaluations and Eating Evaluations/Nutritional Management Plans reviewed contained recommendations for formal OT supports/services with the exception of dining plan recommendations. Recommendations were made for mealtime positioning, eating status, food/liquid texture, adaptive equipment, and suggested eating techniques to be incorporated into an individual's dining plan. The large caseloads of Occupational Therapists, and the responsibility of completing evaluations appeared not to leave additional time to provide direct therapy. As stated above with regard to Section 0.6 of the SA, there were multiple monitoring forms, but policy/procedures had not been developed to define the monitoring process and address the components above.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>P1</td><td>By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with</td><td><u>The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u>
There were 452 individuals living at ABSSLC. The following chart represented the current caseloads of the Occupational Therapists and Physical Therapists:

<table><tr><th>Occupational Therapist(s)</th><th>Current Caseloads and Responsibility</th></tr><tr><td>OT #1</td><td>202 individuals and Lead OT</td></tr><tr><td>OT #2</td><td>189 individuals</td></tr></table></td><td>Noncompliance</td></tr>
</table>

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	therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<table><tr><td>OT #3 (part time)</td><td>61 individuals</td></tr><tr><td>Physical Therapist(s)</td><td>Current Caseload</td></tr><tr><td>PT #1</td><td>134 individuals and Lead Physical Therapist</td></tr><tr><td>PT #2</td><td>91 individuals</td></tr><tr><td>PT #3</td><td>116 individuals</td></tr><tr><td>PT #4</td><td>111 individuals</td></tr></table> There were six budgeted positions for Occupational Therapy. At the time of the review, there were three vacancies for Occupational Therapy. The Occupational Therapist with a caseload of 202 individuals was the Lead Occupational Therapist, supervising PNMP Coordinators (10 positions), and providing oversight to Home Program Technicians (13 positions), as well as being a standing member of the NMT. At the time of the site visit, a supervisor had been hired to supervise the PNMP Coordinators and Home Program Technicians, although the Lead Occupational Therapist would supervise this position. There were five Physical Therapy budgeted positions, including the Habilitation Therapies Director, and four staff Physical Therapists. There were no Physical Therapy vacancies. The current caseloads for occupational and physical therapists were not sufficient to allow therapists to be active members of the individuals' PSTs, and were presenting significant challenges in meeting the standards set forth in the SA and Health Care Guidelines. Based on a review of CVs for each therapy clinician (seven clinicians) and interviews with therapy staff, the appropriate qualifications were found for licensed OTs and PTs. The OTs and PTs CVs documented continuing educations courses within the past 12 months. Clinical instruction was documented in the following areas in the last 12 months: ▪ Habilitation Therapies Annual Conference; ▪ Clinical Symposium on Advances in Skin and Wound Care; ▪ Issues in Evaluation and Treatment of Individuals with Developmental Disabilities; ▪ PNMP and Wheelchair Clinic Teleconference; ▪ Eating Disorders Across the Lifespan: A Closer Look; ▪ Technological Advances in the Management of Dysphagia; ▪ Total Joint Replacement Program; ▪ Role of Manual Therapy in Pediatric Orthopedics; ▪ Differential Diagnosis of Vestibular Problems;	

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		▪ Dealing with Dementia in a Rehabilitation Setting; ▪ Community with Patients who have Aphasia; and ▪ Therapy in Spanish. The Facility should continue to support therapists to attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at ABSSLC. The Master Program List (as of 7/5/10) documented 142 individuals (31% of ABSSLC census) were receiving a therapy-related activity in their home, Habilitation Therapies Center (HTC), and/or the Sensory Gym. Fifty-one of these therapy-related activities occurred in the HTC, 86 therapy-related programs occurred in the individual's residence and the remaining 5 occurred at the HTC and in the individual's home. Eighteen (18) records were reviewed, including those for: Individual #254, Individual #337, Individual #21, Individual #232, Individual #447, Individual #401, Individual #431, Individual #206, Individual #377, Individual #118, Individual #73, Individual #100, Individual #478, Individual #58, Individual #219, Individual #396, Individual #445 and Individual #79. These 18 individuals had identified needs related to movement; mobility; range of motion; and/or independence and regression of functional skills. Of the 18 individuals for whom these needs were identified, 12 individuals (67%) were receiving active PT treatment or participating in a PT program. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> The following individuals (Individual #455, Individual #79, Individual #102, and Individual #328) were recently admitted to ABSSLC and received an OT/PT Initial Evaluation and Eating Evaluation/Nutritional Management Plan within 30 days of admission. The admission evaluations were not signed or dated by the respective occupational and/or physical therapist(s). <u>All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u> Assessment/screening results documented the need for PT supports/services in 12 of the 18 (67%) individual OT/PT evaluations reviewed, but 0 of 18 OT/PT Assessments recommended formal OT supports/services.. The following provides a summary of the findings of the review of these assessments: ▪ Based on review of OT/PT documentation in 18 individual records, all individuals had received an OT/PT assessment and/or screening. Each individual had an OT/PT Annual Evaluation, and an OT/Speech Therapy (ST) Eating Evaluation/Nutritional Management Plan.	

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		▪ In the 18 records reviewed, 12 of the 18 OT/PT evaluations reviewed (67%) documented formal physical therapy supports/services, but no formal OT therapy supports/services were recommended in the 18 records reviewed (0%). ▪ Eating Evaluation/Nutritional Management Plan were completed for the 18 individuals reviewed (100%). The following specific individual concerns were identified: ▪ Individual #337's OT/PT Evaluation was completed on 1/29/03. He started a formal sensory program in August 2007 to "relax and integrate his sensory systems to develop better ability to filter sensory input, a better body scheme, more postural security and improve motor planning" (PT Service Plan, dated 8/4/09). This program recently was discontinued due to lack of progress (OT Update, dated 8/3/10). His OT/PT evaluation had not been updated since 2003. ▪ Individual #396's OT/PT Evaluation was dated 9/11/00. A Physical Therapy Update, dated 10/12/09, documented Individual #396 had a left tibial/fibula fracture, and it was recommended that she "continues to attend an informal program with the PT at the PT department once a week." The PT Update, dated 11/2/09, stated that Individual #396 "requested wheelchair gloves." She had relied on her wheelchair as her primary mode of transportation since her left lower extremity fracture. An OT/PT update and/or Seating Assessment had not been completed in response to her change in status. ▪ Individual #100's OT/PT Evaluation was dated 9/15/05. He received an MBS on 7/2/09 with a diagnosis of severe dysphagia. The recommendations were "NPO due to passive silent aspiration of all attempted textures with prior history of silent aspiration of thin liquids. Additionally, his history of recurrent pneumonias, medication toxicity, and fluctuating levels of alertness indicate a need for alternate means of nutritional intake to ensure his safety and optimal nutritional status." The Eating Evaluation/Nutritional Management Plan, dated 8/3/09, stated he "receives all of his nutrition via G-tube. His gastrostomy tube was placed on 7/14/09 due to MBS results on 7/2/09 indicating passive aspiration and ineffective coughing. He had had ongoing problems with frequent episodes of pneumonia. Therefore, oral/gustatory stimulation is not provided or recommended." Individual #100 had not received a seating/alternate positioning assessment to determine if his current seating system and alternate positions were providing optimal alignment and support to minimize his risk of aspiration pneumonia. ▪ Individual #58 and Individual #219 were planning to transition to the community. These individuals' OT/PT Annual Evaluations did not discuss and/or provide recommendations to assist in a successful transition to the	

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		community. OT/PT Therapy Evaluations should address transition for those individuals who are scheduled to leave ABSSLC, and provide relevant information within evaluations. Eighteen OT/PT evaluations and Eating Evaluations/Nutritional Management Plans were reviewed, and none (0%) of the 18 records contained recommendations for formal OT supports/services with the exception of dining plan recommendations. Recommendations were made for mealtime position, eating status, food/liquid texture, adaptive equipment, and suggested eating techniques to be incorporated into an individual's dining plan. There were no recommendations made in these evaluations for formal OT therapy supports/services. Due to the limited number of occupational therapists on campus and their current caseloads, these therapists are likely challenged just to complete annual OT/PT evaluations, as well as the Eating Evaluation/Nutritional Management Plan and Addendums. The large caseloads of Occupational Therapists and the responsibility of completing evaluations did not leave additional time to provide direct therapy, which was supported by the absence of formal OT therapy programs found in the individual record review of 18 individuals. The following issues were identified in the individual records reviewed: ▪ Individual #445's OT/PT Evaluation (4/27/10) documented "participate in sensory gym activities 2-3 times a week in order to provide additional sensory experiences to help improve self-regulation and coordination. **Participation in this programming is currently pending. OT/PT will look over the current schedule and determine what changes can be made in order to find a time slot for Individual #445 to attend." Recommendations were made to the PST for consideration of the following training objectives: o "Increase his independence in activities of daily living: dressing, washing his hair, learning to attach Velcro fasteners on shoes, learning to pick out and get his own healthy snacks." There were no recommendations for formal therapy goals. ▪ Individual #79's OT/PT evaluation, dated 5/11/10, did not recommend formal therapy goals although her assessment documented significant potential. Recommendations to the PST were: consider establishing opportunities where Individual #79 may be given the limited use of a computer, perhaps coupled with formal classes and/or training for keyboard use, data entry, and graphic art design through free online sites, etc. with focus on possibility of broadening employment opportunities on campus; providing various art supply mediums for functional leisure time activities; make these activities part of a training objectives such as completion of a project prior to starting another, etc.; and training objectives in secondary activities of daily living (ADLs) such as laundry skills, bedroom grooming/hygiene, such as dusting personal furniture,	

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		changing sheets, and making her bed. These recommendations support engagement in functional activities at home, work and in leisure activities. However, no formal goals or therapy were recommended. The OT/PT annual evaluations were providing functional recommendations to the PST for consideration, but it appeared there were not adequate professional staff that were proficient or had the time available to develop and implement a program to implement these functional recommendations. The Monitoring Team acknowledges that the current caseload of Occupational Therapists significantly impacted their ability to develop and implement therapy programs to support the acquisition of functional skills at home, work and in leisure activities. The following chart identifies the formal physical therapy programs provided to 12 of the 18 individuals reviewed:	

Individual	Therapy Program
Individual #118	General range of motion to promote joint movement, and increased participation in daily activities.
Individual #478	General range of motion, and progressive strengthening exercise program.
Individual #232	Range of motion exercise program to promote joint movement and to increase his ability to be assisted during daily activities.
Individual #254	Home exercise program to promote joint movement and increased participation in daily activities.
Individual #401	Therapeutic exercise (including general range of motion, and muscle recruitment, core strengthening/ stabilization exercises), and progressive weight bearing/ambulation activities to help increase her participation in daily activities.
Individual #21	Range of motion program to help reduce further contractures, promote health skin integrity, and reduce the risk of skin breakdown.
Individual #73	Ambulation program to increase her activity level, provide opportunities for increased weight bearing, and maintain ambulation skills.
Individual #447	Lower extremity range of motion, therapeutic exercises, and progressive ambulation program.
Individual #431	Home exercise program for joint movement.
Individual #337	Ambulation activities in the ARJO walker to increase weight-bearing activities throughout her day.

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Individual #206	Properly positioned to promote healthy skin integrity.
Individual #100	Progressive ambulation, and therapeutic exercise program.

The following comments are provided with regard to these individuals' PT programs:

- Individual #401's OT/PT Initial Evaluation, dated 3/5/10, did not recommend a formal therapy program. The initial evaluation recommended the PST consider the following:
  - Offering her slow movement prior to engaging in activities;
  - Encourage staff to go for walks in or out of the home and to use slow rocking with the wheelchair rocker prior to training activities;
  - To improve body awareness/spatial relations, establish training objective whereby staff initially talk with her during ADL, especially bathing and dressing to identify major body parts;
  - Establish a training objective to encourage independent drinking from her assistive cup consistently during meals;
  - Establish a training objective to increase participation in dressing; and
  - Establish a training objective to hold a wash cloth during bathing, progressing to hand-over-hand assistance in washing a particular area, progressing to staff physically prompting her to independently wash with a soapy cloth a particular area during her bath such as her face, chest or belly.

  PT Service Plan, dated 4/20/10, documented an objective for therapeutic exercise (including general range of motion, and muscle recruitment, core strengthening/stabilization activities), and progressive weight bearing/ambulation activities to help increase her participation in daily activities. There was no update to the OT/PT Initial Evaluation to discuss the initiation of or need for a therapeutic exercise program.
- Individual #337's OT/PT Evaluation was dated 1/29/03. It included a recommendation "to initiate process with OT to develop a sensory program for Individual #337 at the OT/PT center." The OT Update, dated 8/3/10, recommended the program be discontinued as the "home program technician reports that [Individual #337] has had no change in the past year and is no longer benefiting from this program." Individual #337 had not received an OT/PT update evaluation subsequent to his 2003 OT/PT evaluation.
- Individual #21's OT/PT Annual Evaluation, dated 11/16/09, recommended: "continue PT Service Plan to maintain or improve joint range of motion." His assessment did not discuss his past progress or justification to continue this program. The evaluation made the following recommendations to the PST:
  - Future training objectives for Steridents tooth brushing skills;
  - Lotion massages to shoulders, arms, hands, and the legs below the

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		knees to provide additional proprioceptive input to the sensory system; o Choice-making skills combined with auditory stimulation via music listening opportunities; and o Hand-over-hand training to place coins of different values into piggy bank and making small purchases for his room. It was unclear why the therapist did not develop, and implement functional therapy programs for these recommendations. ▪ Individual #100's OT/PT Evaluation, dated 9/15/05, did not recommend "active therapy services programs or formal physical therapy programs as at this time he ambulates with only standby assistance and is able to reposition himself in chair and bed." His PT Service Plan's objective was "to be provided with progressive ambulation and therapeutic exercise program." Individual #100 had not received an OT/PT evaluation update subsequent to his 2005 OT/PT evaluation. The following individual's OT/PT evaluation did not recommend formal programs. The following concerns were noted with regard to this individual: ▪ Individual #58's OT/PT Annual Evaluation, dated 9/23/09, did not recommend a formal therapy program. The evaluation suggested the PSP consider the following: o Provide a spin toothbrush with training objective to also include skills of following up with appropriate mouthwash. Doing this might improve his oral hygiene, compliance, and/or improve general low oral tone; o Training objective to learn to stand still after getting up from chair/bed levels, for a few seconds, to gain equilibrium and balance prior to walking /moving about; o Staff should be alert to when Individual #58 begins to stand up from a chair and verbally prompt him to "stand tall," and gain balance prior to initiating gait in order to decrease risk of falling. The evaluation documented that Individual #58 had six recorded episodes of falling in the past year. It was unclear why a formal therapy program was not recommended to address his risk of falling. <u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u> Based on individual record reviews, 13 of the 18 individuals (72%) reviewed had received a comprehensive OT/PT assessment within the last three years. However, as noted in the examples provided above, it did not appear that these assessments were	

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		updated consistently when there were changes in status. This appeared to be the case, for example, with Individual #401. At a minimum, the comprehensive OT/PT assessment addressed the following elements: a. Movement; b. Mobility; c. Range of motion; d. Independence; and e. Functional Status across each of these areas. <u>Findings of comprehensive assessment drive the need for further assessment such a wheelchair/seating assessment.</u> Examples of assessments that did not contain probes for additional assessment included: ▪ Individual #337's OT/PT Evaluation, dated 1/29/03, did not recommend a seating system/alternate positioning assessment. His PNMP, revised 4/26/10, documented the use of a wheelchair. ▪ Individual #73's PNMP documented the use of a wheelchair, and a wedge to elevate the head of her bed. The evaluation documented Individual #73 attended "PNMP clinic on 9/4/09 with PT, OT, Orthotics and nursing. The team agreed she would benefit from a frame with tilt, contoured back, planar seat, removable footrest and padded armrests. PT submitted a work order to orthotics on 9/24/09 (as a priority one) in order to begin fabrication of her new wheelchair." Her OT/PT Annual Evaluation, dated 10/1/09, did not recommend a seating system/alternate positioning assessment to review the appropriateness of her current seating system, as well as alternate positions. A seating system assessment was not submitted in response to the Monitoring Team's document request. Her Physical Therapy Update, dated 7/24/10, documented the receipt of a new wheelchair, which apparently was fabricated without the benefit of a seating system/alternate positioning assessment. ▪ Individual #396's OT/PT Evaluation, dated 9/11/00, did not recommend a seating system assessment. Her PNMP, dated 3/24/10, documented the use of a wheelchair, but a seating system assessment had not been completed. ▪ Individual #100's OT/PT Evaluation, dated 9/15/05, did not recommend a seating system/alternate positioning assessment. His PNMP, revised 2/3/10, documented the use of a wheelchair and alternate positions. A seating system assessment/alternate positioning assessment had not been completed. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic</u>	

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		interventions. Three of the 18 (16%) assessments reviewed addressed medical issues and health risk indicators as identified via a plan, support or service or if not, provided sufficient rationale as to why not. Examples of assessments that did not provide an appropriate plan or rationale included: ▪ Individual #100 OT/PT Evaluation had not been updated since September 2005. His evaluation under diagnoses and pertinent history referred to the Annual Medical Summary and Physical Examination, dated 8/30/05. At the time of the review, he was being provided direct PT therapy to address ambulation issues. Apparently, his physical/medical status had changed since 2005, but due to a lack of an updated evaluation reflecting any such changes, his most "current" evaluation did not adequately address relevant health and risk indicators. ▪ Individual #118's OT/PT Evaluation, dated 2/18/10, documented active problems such as congenital hip dislocation, osteopenia, minimal esophagitis, history of poor eating/refusal to eat, and anorexia. These medical issues and/or health risk indicators were not discussed in the assessment. Evidence of communication and or collaboration is present in the OT/PT assessments. Based on record review, two of 18 OT/PT assessments (11%) included signatures and date of both the OT and PT.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices	Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP. Based on review of comprehensive OT/PT assessments or updates and PT Service Plans seven of eight individuals (88%) (Individual #118, Individual #478, Individual #232, Individual #254, Individual #401, Individual #21, Individual #73, and Individual #447), had PT Service and/or Home Exercise plans were developed within 30 days of the date of the assessment/update. Within 30 days of development of the plan, it was implemented Based on review of PSP meeting dates, eight of eight (100%) of the above plans were implemented within 30 days of development of the PSP. Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes. Intervention plans for the sample identified above were based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies for three of eight individuals reviewed (Individual #118, Individual #73 and	Noncompliance

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	and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Individual #447) (38%). Goal statements in the intervention plans for the above were: ▪ Stated in objective terms for 0 of 8 individuals reviewed (0%); ▪ Measurable for 0 of 8 individuals reviewed (0%); and ▪ Functional for of 7 of 8 individuals reviewed (88%). The PT Service Plans reviewed identified the: ▪ Frequency of implementation in 8 out of 8 (100%) cases; ▪ Data collection criteria and data collection format in 0 out of 8 (0%); and ▪ Staff responsible for implementation in 8 out of 8 (100%) cases. <u>Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression. (HCG VIII.B.2)</u> Intervention plans for the eight plans reviewed (Individual #118, Individual #478, Individual #232, Individual #254, Individual #401, Individual #21, Individual #73, and Individual #447) addressed the following as appropriate: ▪ Movement: one PT Service Plan (Individual 254); ▪ Mobility: three PT Service Plans (Individual #73, Individual #401, and Individual #447); ▪ Range of motion: six PT Service Plans (Individual #118, Individual #21, Individual #401, Individual #478, Individual #232, and Individual #447); and ▪ Minimize regression: No PT Service Plan stated purpose was to minimize regression. <u>The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.</u> Based on reviews of PNMPs and other positioning plans for eight individuals, the rationale for the plans were clearly stated in the OT/PT assessment, Based on reviews of PNMPs and other positioning plans for 8 individuals, equipment was specified and identified in a photograph(s) for 0 of 8 plans reviewed (0%). <u>On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.</u> Based on review of OT/PT documentation for individuals in the sample, there was evidence that each individual was reviewed at least monthly for OT/PT Status for 0 of 8 individuals reviewed (0%). For example: • Individual #118's PT Program Review Objective Data Sheet(s) were submitted for three months. The data sheet documented the reporting period, areas (hip	

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		extension, hip abduction, knee extension and dorsiflection), sessions, tolerance, time distance, behavior and initials. There were no updates provided by the therapist. • There were no monthly progress notes submitted by the therapists for individuals reviewed in the sample. Based on review of PNMP monitoring for the individuals in the sample, intervention plans were modified as indicated by findings for 0 of 8 individuals. There was no PNMP monitoring completed for the individuals in the sample.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Staff implements recommendations identified by OT/PT.</u> Based on observations of OT/PT interventions all PNMPs or other intervention plans were not implemented. More specifically, during observation of a PNMP Coordinator in a dining room and during medication administration, the PNMP Coordinator did not intervene to coach staff during a dinner observation for correct alignment and support, presentation of incorrect diet texture and fluid consistency and incorrect presentation techniques. Observations by the Monitoring Team did not support that PNMP Coordinator(s) had achieved competency in the provision of foundational physical and nutritional support service delivery. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs. Therapists need to conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.</u>	Noncompliance

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		Based on review of training rosters and in-service outlines, direct support staff, PNMP Coordinators and therapy aides were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for 0 of 8 individuals reviewed (0%) in the sample. For example: ▪ Individual #118's Eating Evaluation (2/24/10) Training Roster documented "verbal" competency training by a Home Program Technician to 26 staff. There was no demonstration of competency completed by direct support professionals on the implementation of his dining plan. ▪ Individual #401's final PNMP Training Roster, dated 4/2/10 had nine staff signatures on the 6 a.m. to 2 p.m. shift, 10 staff signatures on two p.m. to 10 p.m. shift, and 7 staff on 10 p.m. to 6 a.m. shift. There was no documentation of demonstration of competency on the training roster. ▪ There was no additional person-specific competency-based training documentation submitted for the individuals in this sample.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	<u>System exists to routinely evaluate: fit, availability, function, and condition of all adaptive equipment/assistive technology.</u> The Habilitation Therapies Manual, revised 5/13/10, PNMP Clinic and Equipment Review documented the procedures and general guidelines for reviewing information during the PNMP Clinic. The PNMP Clinic individual document reviewed an individual's: ▪ PNMP; ▪ Therapy Evaluation dates; ▪ Wheelchair modifications/repairs, cleanliness, fit/function; ▪ Communication equipment status; ▪ PT/OT Consultations; ▪ PT/OT Updates; ▪ Work orders; ▪ Annual Orders (OT/PT Programming, OT/PT equipment, Head of Bed (HOB) elevated, texture, recommended weight range and current weight); ▪ Nutritional Management Team; ▪ Discussion of medications; ▪ Risk factors; and ▪ Recommendations. Based on a review of PNMP Clinic documentation, 3 of 8 (38%) individuals' PNMP Clinic results documented a review of adaptive equipment/assistive technology supports. At the time of the baseline review, the Orthotics Department was not able to complete new construction, routine maintenance, alterations and preventative maintenance in a timely manner. There were two vacancies in the Orthotics Department since November 2009. Per interview, the Director of Orthotics was in the process of recruiting for these	Noncompliance

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		positions. These vacancies were impacting the timely delivery of new wheelchairs, as well as completing routine maintenance, alterations and preventative maintenance. Since the baseline review, the vacant positions had been filled within the Orthotics department. In addition, the Habilitation Therapy Administrative Assistant had established a tracking system for Orthotics work orders to ensure timely delivery. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions. Such a system should include: ▪ Definition of monitoring process; ▪ Identification of monitors (licensed professional for OT/PT intervention plans), and their roles and responsibilities; ▪ Formal schedule for monitoring to occur; ▪ Process for monitors to be re-validated on an annual basis by therapists and/or assistants; and ▪ Description of how when results of monitoring activities, note deficiencies, they are formally shared for appropriate follow-up by the relevant supervisor. As stated above with regard to Section 0.6 of the SA, there were multiple monitoring forms, but policy/procedures had not been developed to define the monitoring process and address the components above. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> A policy did not exist that clearly defined the details of the monitoring system including frequency, and implementation. Such a system should require that the program author review intervention plans monthly, including observation of staff implementation of the plans. <u>For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (Refer to Section O-5).</u> As noted above, issues were identified related to the competencies of PNMP Coordinators, who had responsibility for working with the individuals with the most complex needs and monitoring other staff's competence, particularly with regard to transferring individuals. It is essential that these staff as well as Home Program Technicians consistently demonstrate competence in these areas.	

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		Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (Refer to O-4). As noted above, a system for monitoring had not been developed and memorialized in policy. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. Individual PNMP Clinic results documented the annual review of the appropriateness of adaptive equipment and assistive technology supports although the following individuals within the record sample did not have a SLP in attendance at the PNMP Clinic to review assistive technology supports: Individual #21, Individual #254, Individual #478, Individual #232. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (Refer to Section O-5). As noted above, a system for monitoring had not been developed and memorialized in policy. Data collection method is validated by the program's author(s). As noted above, a system for monitoring had not been developed and memorialized in policy.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility should complete an analysis to determine needed OT/PT therapy positions to support these professionals being active members of individuals' PSTs. Efforts should continue to fill currently vacant OT positions.
2. PNMP Coordinators should receive competency-based physical assistance and mealtime supports training with specific learning objectives and competencies identified. Such training should provide foundational knowledge and skills related to the appropriate implementation of physical assistance supports, including but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; mealtime position and alignment; diet texture and consistency; presentation techniques to enhance nutritional intake and hydration; care and use of adaptive equipment; aspiration and choking precautions and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs.
3. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required.
4. Policies/procedures should be developed for the OT/PT monitoring system with identified performance indicators that are defined clearly. This system should include, but not be limited to: a systematic and routine review of the components of PNMPs and related equipment; OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o ABSSLC Attendance Tracking Worksheet January to July 2010; o ABSSLC Emergency Exam Tracking Worksheet January to July 2010; o ABSSLC Residents Receiving Preventive Dental Care January 2010 to July 2010, no duplicates; o ABSSLC Residents Receiving Preventive Dental Care January 2010 to July 2010, all instances; o ABSSLC Admissions January to July 2010; o ABSSLC Admission Tracking Sheet 8/28/01 to 7/11/10; o ABSSLC Restorations January to July 2010; o ABSSLC Extractions Tracking Worksheet January to July 2010; o Behavior Protocol for Desensitization, 5/20/10; o Restraint and sedation tracking list June 2010 (dental); o People recommended to use the Steridentt toothbrush, revised 7/8/10; o Instructions, use and care for Steridentt, dated 9/10/09; o ABSSLC Steridentt and Vacuum tooth-brushing policy, revised July 2010; o Dental records for the following individuals: Individual #548, Individual #500, Individual # 106, Individual #424, Individual #144, Individual #25, Individual #368, Individual #158, Individual #152, Individual #124, Individual #258, Individual #328, Individual #274, Individual #344, Individual #58, and Individual #387; o ABSSLC Oral Hygiene Training Process for Residents; o Oral hygiene program documents for the following individuals: Individual #534, Individual #237, and Individual #442; o ABSSLC Dental Operating and Procedural Manual, published January 27, 2010, Sections 2, 4 and 5; o Monitoring Tapes during dental visits for the following individuals: Individual #104, Individual #99, and Individual #387; o Dental records for extractions: Individual #169, Individual #401, Individual #219, Individual #159, and Individual #281; o Dental record for crown lengthening for Individual #51; o Progress record, dental entries: Individual #10, Individual #100, Individual #322, Individual #511, Individual #294, Individual #328, and Individual #274; o Dental Department Corrective Action Plan, updated June 2010; o Presentation for 8/2/10 Settlement Agreement Monitoring Team visit; o Individuals scheduled for general anesthesia with procedure listed September 2009 to October 2010; o Samples of Memos from Dental Department to QMRP for assigned individuals with missed appointments in June 2010, dated 7/6/10; o Samples of Memos from Dental Department to QMRP for assigned individuals with

	required restraints and/or sedation for the appointments in June 2010, dated 7/6/10; o ABSSLC Distribution of Dental Data Worksheets to QMRP for PST action, draft copy; o Restraint and sedation tracking list January 2010 to July 2010; and o ABSSLC Pre-Treatment Sedation Monitoring Plan for Dental Procedures, dated 6/3/10 ▪ **Interviews with**: o Jerry Griffin, DDS, Dental Director ▪ **Observations of**: o Tour of Dental Office
	Facility Self-Assessment: Each of the two provisions included in this section of the SA encompass a variety of requirements with regard to dental care. Based on the Facility's POI, it would appear that the Dental Department understood that it had met some areas of each of these two provisions, but continued to need to make improvements to be successful in all the aspects of the requirements. Although the methodologies for conducting the self-assessment were not included in the POI, the Facility appeared to have identified many the same areas as being in compliance as the Monitoring Team did. For example, the Dental Department had completed documentation of the annual exams and any acute care exams, and it provided a full scope of dental services, with emphasis on oral hygiene. The Dental Department had made all information available through the medical record, and all notations were in the integrated progress notes, so the PST had the latest information available.
	Summary of Monitor's Assessment: The addition of a dental hygienist had allowed for the development of an oral health program with selected individuals. Recruitment for a full-time dentist was continuing. The number of missed appointment was impressively small, but there was the problem of not having accurate data for those appointments that were missed. This is necessary in order to reach the goal of continued reduction in missed appointments. The number of chemical and mechanical /physical restraints remained high. There needs to be a goal with a related action plan to diminish the numbers of restraints used. Desensitization plans or other strategies to reduce the need for restraint were not available to the majority of individuals who would benefit from such programs.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment,	In the recent past, the Dental Department hired two dental hygienists and an office clerk. A full-time dentist position remained open. At the time of the review, there was one full-time dentist who also served as the Dental Director, two dental assistants, two dental hygienists, and a Dental Department clerk. Recruitment of the second full-time dentist remained a concern. There were no pending applicants. The State recently had increased salary rates for the dental position, and may need to consider seeking direction from the state dental society/association concerning additional steps needed to successfully	Noncompliance

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	consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	recruit a dentist to ABSSLC. The State Office has been responsive in making recruitment competitive for the primary care physicians, but this same success had not occurred in dental services, suggesting other and more creative recruitment steps were necessary. An additional positive aspect of the dentist position was that the successful candidate would be able to be mentored by the Dental Director, who had spent many years of service in the dental care of the ID/DD population. An area of concern with dentistry when working with the ID/DD population is the amount of missed appointments and delay in treatment. The Dental Department at ABSSLC had the goal of getting all individuals to complete a successful visit during the same calendar month as originally scheduled. This meant at times several visits in the same month to achieve this goal. This had led to a high success rate in completion of dental visits. For those who refused to attend or cooperate to achieve a successful visit, the attendance tracking worksheets were reviewed from January to July 2010. For those that refused the visit, 29 individuals who initially missed an appointment had a successful visit on a follow up appointment. It required between one and nine appointments to attain a successful visit. The following provide some examples of the resulting delay in care: ▪ There was a significant delay in treatment of Individual # 244, approximately a three-month interval of attempts before the office visit was considered successful. ▪ Individual # 276 had behavioral issues on 2/22/10, and an unsuccessful appointment on 3/3/10, and did not show up on the attendance tracking form until 6/17/10, but had to be rescheduled for 6/22/10. There were only eight individuals for whom information was pending, or who had to be rescheduled for another appointment. Except for the eight individuals with recent data not entered and one to be rescheduled, it appeared that 100% of individuals attained a successful visit with this approach, although not always timely. Of those listed as "no shows," all indicated a second follow up visit was successful (except for unentered data in June and July.) A total of 18 "no show" visits subsequently had a successful visit. Only two "no shows" in July had no data entry for follow-up. For those listed as cancelled (27) due to individual reasons, only one had no data entries. All the others had a successful visit at some point. The dental office was listed as a cause of cancelled appointments during this six-month period for a total of 24 visits. There were a number of other entries for missed appointments, including "sick," "conflict," "no meds," "high bp [blood pressure]," and "reschedule." There were few that did not have a subsequent successful visit, and most of these were pending data entry. From review of this information, the follow through until completion of a successful visit was excellent. It was evident from the data that the categorization for missed	

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		appointments was subjective, especially for those individuals with delays in treatment. The dental department needs to learn the reason for the missed appointments in order to begin to resolve these issues. At times the dental department was told that the individual cancelled the appointment (which could be due to a variety of reasons, such as conflict in schedule, illness, etc), when they may have refused to attend, which would suggest a need for assistance from psychology or further training on a behavioral plan. It is recommended that clear definitions be developed for each of these categories in order to develop accurate information to further reduce the initial "no show" rate. There was frustration at times in that little information could be obtained from the unit as to the actual cause of the missed appointment. The Dental Department was unable to develop accurate baseline information regarding missed appointments, because the information that it received was unclear or lacking. It is recommended that the Dental Department create a brief communication form, which could be sent to the units for their completion and return to the Dental Department. Although the Dental Department called the unit in attempts to obtain information, the written statements could theoretically provide timely and accurate information. The personnel completing the form also would be accountable for the accuracy of this information. Because of the lack of accurate information with missed appointments, the Dental Department developed a corrective action plan that was recently implemented. For those with a missed dental appointment, those needing mechanical restraints, and those needing chemical sedation, a list was sent to each QMRP to be discussed in the next PSP meeting. June information was sent to the QMRPs as of 7/6/10. In Memo form, the information included the name of the individual(s) assigned to the QMRP and the reason for the request: missed appointment, or required mechanical restraints /sedation for the dental procedure. At times, the Dental Director or a designee from the Dental Department attended the PST in order to ensure the dental concern was being addressed and progress was made in reducing missed appointment rates, or to ensure review of chemical sedation requirements for an individual. Although the Dental Director's attendance at PSP meetings was certainly an effective step, it was a time consuming and inefficient step for a department with only one dentist. A total of 294 individuals had a preventive dental visit between January 1 and July 31, 2010. This represents over half the population, and suggested the entire population has been successful in receiving preventive dental care over the year. During the time period from January 1 through July 31, 2010, for these 294 individuals previously mentioned, there were 751 completed preventive dental visits. It was explained that many individuals were scheduled with frequent dental office visits because this step had a positive impact on improved dental hygiene. Initially left and right oblique mandible views were obtained on all those with teeth (to	

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		determine bone levels, abscess formation, impacted teeth, large caries, and foreign bodies.) Except for one individual, these x-rays were obtained on everyone who had teeth. Additional bitewing x-ray views were obtained if there was a history of caries and the dentist was suspecting caries between the teeth. Films were repeated every three to five years depending on the history and risk of the individual. Everyone on campus received topical fluoride treatment. The city water did not include sufficient fluoride. There were seven individuals considered new admissions from January 1 to July 31, 2010. Of these, all completed a dental exam; four were completed within 30 days, two within 60 days, and one within 90 days of admission. This was not in accordance with the ABSSLC Dental Operating and Procedure manual published January 27, 2010, Dental Staff Regulations and By-Laws that read: "#2.3. Ordinary admissions to Abilene State Supported Living Center shall receive a dental examination within thirty days of admission." The compliance rate according to the Dental Department standards was 57%. Timeliness of the annual evaluation was reviewed in the dental record of Individual #344, who was admitted in 7/06. The initial examination report was 7/21/06, with subsequent annuals on 6/5/07, and 6/2/08. There was no submission of information after 2008. The dental record of Individual #58 indicated he was admitted in 9/06, and no initial evaluation was submitted, but annual examinations were dated 8/7/07, 8/4/08, 7/6/09, and 7/13/10. Forty-one individuals underwent restorative care from January 1 through July 31, 2010, for a total of 49 visits. Extractions also were completed on 23 individuals, ranging from a single tooth extraction to a full mouth extraction. Dental records were reviewed for the following individuals who underwent extractions: Individual #169, Individual #401, Individual #219, and Individual #159. The following provides a summary of these records: ▪ Individual #159 underwent a tooth extraction under local anesthesia on 6/8/10. There was documentation of informed consent, preoperative medical clearance with review on 6/8/10, review of medical history and allergies, vital signs, postoperative vital signs, and follow-up dental exams on 6/16/10 and 7/8/10. The other individuals underwent multiple extractions under general anesthesia, including: ▪ Individual #169 underwent extraction of three teeth. Documentation included an initial dental evaluation for new behavior due to dental discomfort on 3/10/10, dental x-rays on 3/10/10, informed consent, second opinion and oral surgery note on 5/11/10, operative record, intra-operative record, recovery room record, post-operative oral surgery note on 5/11/10, and summary of	

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		Infirmary stay. ▪ Individual #401 underwent a full mouth extraction on 5/11/10. Documentation included a 2/22/10 dental note with dental treatment plan, dental x-rays on 2/22/10, a second opinion by an oral surgeon on 3/10/10, informed consent, oral surgery operative note, operative record, general anesthesia intra-operative record, recovery room record, post-operative note 2:20 p.m., several nursing notes post operatively in Infirmary, summary of Infirmary stay, and note from nurse in home. ▪ Individual #219 had four teeth extracted on 3/10/10. Documentation included dental examination on 3/4/10, oral surgery second opinion on 3/10/10, dental x-rays on 4/8/10, informed consent, oral surgery note on 5/11/10, operative record, intra-operative record, recovery room record, post-operative note on 5/11/10, and summary of Infirmary stay. Those with multiple extractions and undergoing general anesthesia had second opinions. Post-operative notes were recorded in all instances. Dental records also were reviewed for two individuals with additional dental work, including: ▪ Individual #281 had an annual dental exam on 12/10/09; x-ray on 12/10/09 indicating no carious lesions, but an impacted tooth; a second opinion by an oral surgeon on 12/14/09; preoperative clearance on 1/13/10; preoperative labs ordered on 1/14/10; admission note to Infirmary on 1/25/10; overnight Infirmary summary 1/25 to 1/26/10; a 1/26/10 oral surgery operative note; and notes regarding the development of a post anesthesia ileus with vomiting (notes 1/28/10, and 1/30/10). All these notes were included in the integrated progress notes of his record and were available to the entire PST. ▪ Individual #51 underwent crown lengthening on 3/12/10. Documentation included informed consent on 2/21/10, operative record dated 3/12/10, intra-operative record on 3/12/10, recovery room record on 3/12/10, informed consent on 4/11/10, operative record on 4/23/10, intra-operative record, recovery room record on 4/23/10, summary of acute illness on 4/23/10, informed consent on 5/7/10, operative record on 5/21/10, intra-operative record on 5/21/10, recovery room record on 5/21/10, and summary of Infirmary stay on 5/21/10. This case indicated the breadth of services provided to the individuals residing at ABSSLC. This individual required three operations under general anesthesia to complete crown work. Intra-operative and post-operative documentation was complete. Timeliness of emergent care was reviewed using the ABSSLC Emergency Exam Tracking Worksheet January to July 2010. The total number of emergency visits for this period	

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		was 46 visits. The dental office appeared to be accommodating to the needs of the individuals. For example: ▪ For Individual #228, two emergency visits occurred, one on 1/7/10 and the following day on 1/8/10. ▪ Individual #321 had two emergency visits on 6/2/10 and 6/21/10. ▪ Individual #59 had four emergency visits on 6/3/10, 6/9/10, 6/11/10, and 6/16/10. ▪ Individual #387 was seen for a fractured tooth on 4/5/10. Because of difficulty with cooperation, he was seen on 6/11/10 with pre-treatment sedation of chloral hydrate. It had minimal effect, and x-rays were obtained. He was to be scheduled for general anesthesia evaluation and treatment. Dental records were reviewed for the following individuals: Individual #548, Individual #500, Individual #106, Individual #424, Individual #144, Individual #25, Individual #368, Individual #158, Individual #152, Individual #124, Individual #258, Individual #328, and Individual #274. In 100 percent of the dental records, there was documentation concerning the reason for the exam, dental procedures completed, radiographs taken, vital signs recorded, a written treatment plan, description of gingival, and oral health index rating. Examples of individuals for whom dental care was provided adequately included: ▪ For Individual #258, a need for restorative work was found, and this was scheduled the same month, indicating timely restorative dental treatment. ▪ For Individual #274, additional documentation included 7/22/10 pre-treatment sedation note, dentist note, restraint checklist (chemical and personal), description of effectiveness of pre-treatment sedation, use of personal restraint, and a note concerning difficulty in monitoring the individual. ▪ Individual #10 was seen on 6/2/10 for the complaint of biting on many objects. There were no obvious findings. On 6/14/10, his continued biting on his breathing treatment mask was interpreted as dental pain. He was seen in the dental clinic on 6/15/10 for possible dental discomfort at 11:25 a.m. On exam, there was "nothing unusual. No evidence of dental pathology." He was returned home. In this example, the dental visit occurred in a timely manner to rule out dental pain. Safety in the Dental Department is essential, especially when sedation is given prior to the dental visit, or during the visit. At ABSSLC, the Dental Department monitored the individual during the visit. This information was recorded on tape. The monitoring tapes of three individuals (Individual #104, Individual #99, and Individual #387) were reviewed to determine the level of physiological monitoring. Each sample recorded a ten minute time period of monitoring. Each minute O2 saturation and pulse were recorded. Blood pressure was recorded two to three times in each of the ten-minute samples. This	

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		is consistent with the Dental Operating and Procedure Manual, Dental Services Policy, 4.2c Oral Sedation and General Anesthesia Policy that read: "#5. Residents receiving pre-treatment sedation will be monitored for blood pressure, pulse, and oxygen saturation during treatment if possible. In addition to the usual documentation, a printed record of vital signs will be retained in the dental office if obtainable. …" Additionally, there was a new policy developed through cooperation of the dental and nursing departments, entitled: "ABSSLC Pre-Treatment Sedation Monitoring Plan for Dental Procedures 6/3/10." It outlined the steps of informed consent, physician and dental consultation for the most effective sedation, order for NPO for every chemical sedation for dental procedures, nurse administration of sedation with beginning of restraint checklist, vital sign recording initially, with observation by nurses thereafter until arrival in the dental office. However, there was a period of minimal monitoring of the individual which was concerning. Approximately ten minutes after a dosage was administered in the home, a nurse recorded a blood pressure, pulse, respiratory rate, and oxygen saturation once. If normal, then there were no further vital signs taken. Monitoring was done visually thereafter. The individual was brought to the dental office just prior to the appointment (potentially minutes to an hour after the medication administration). There was no monitoring during transport, and it was not clear who accompanied the individual during transport. There was no indication in the 6/3/10 procedure that a nurse would accompany the individual to the dentist's office. It is recommended that the time period of sedation administration to the time of arrival at the dental office be reviewed. There should be periodic vital signs and other evaluations as indicated by a licensed health professional, particularly if the length of time is substantial. It additionally is recommended that a licensed health professional accompany the individual to the dental office, at which time dental monitoring begins. If a nonprofessional was responsible for the sedated individual during transport, and there was no immediate health professional available during this window of time, then this represented a vulnerable time period in the procedure. The Dental Department also referred individuals to other dental specialists who provided services at ABSSLC or in their private office setting or through the local hospital. This included a variety of specialists: a pediatric dentist, an endodontist, and several oral surgeons (four), some of whom used IV sedation in their private office settings. Dental implants were offered and were done under general anesthesia. Bridges and inlays also were offered in appropriate cases. There was emergency call coverage. The Dental Director took primary on-call, but when not available at night or on weekends, there was coverage from community dentists. The Dental Department provided a system of comprehensive dentistry.	

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		The numbers of individuals who missed appointments negatively impacted provision of adequate dental care. As noted above, this resulted in lengthy delays in care for some individuals. Dental assessments also were not completed consistently within 30 days of individuals being admitted to the Facility. In addition, there were concerns related to the safety of the use of pre-treatment sedation. As a result, the Facility is not in compliance with this provision.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	ABSSLC had a Dental Operating Procedure Manual, published January 27, 2010. Submitted as part of the document request were all the policy statements. This included such sections as General Policy, Dental Staff Regulations and Bylaws, Organizational Chart, Dental Services Policy, and Dental Services Procedures. Policies such as Behavioral Protocol for Desensitization, Steridents and Vacuum Tooth brushing Policy, and Pretreatment Sedation Monitoring Plan for Dental Procedures were not in the dental manual, and approved policies affecting dental practice should be included in a timely manner. Many requirements of the SA need further clarification in the policy and procedure manual, such as timelines for dental needs (i.e., what is ABSSLC's expected/acceptable length of time between identified caries and completion of treatment) or acute care problems (length of time acceptable for identification of a fractured tooth, length of time to complete initial or temporary treatment, as well as length of time to completion of treatment) to ensure timely provision of assessments and dental services and in order to compare actual practice to the expected goal or standard. Policies also were needed reflecting standard protocol and tracking for follow up of missed appointments, mechanical/physical restraint reduction, regular updates in the oral hygiene, as well as a policy reflecting the procedures and protocols of improved oral health initiatives in the home. Many of these areas were being implemented, and were being done well, but there was a need for policy and procedures, as well as documentation of the monitoring process. The policy and procedure manual also should include a policy or protocol concerning monitoring of dental procedures for quality, adverse outcomes/complications, as well as timeliness to provide evidence of SA compliance. Copies of all documents related to dental care were included both in the medical record, and in the Dental Department. There were basically two sets of identical records except the annual evaluation was recorded in the medical record in the integrated progress notes section, and there was only reference to the annual evaluation in the dental progress notes. Any x-rays completed were read by the dentist and placed in the medical record. Due to the large caseload for even two dentists, it is recommended that the dictation system currently utilized by the medical department be expanded to the Dental	Noncompliance

#	Provision	Assessment of Status	Compliance
		Department. The dental annual evaluation was lengthy, and it would save considerable time for the dentist if dictation capabilities were available. For new admissions, a comprehensive exam was completed. Information also was provided on the block diagrams of the teeth. X-rays and oral hygiene was provided. A written treatment plan was written, although the Dental Director stated that development of such a plan could require a series of steps. For large caries or an impacted tooth, an oral surgeon would be required to provide a second opinion. Once written, it went to the QMRP, and then to the PST for approval. Since 4/10, there was also a statement summarizing review of the medical history and any allergies. The Dental Department used the Oral Hygiene Index rating scale (zero to six for those with teeth, six being the best score; seven to nine for those with dentures; and eight to 10 for those without teeth). A behavioral analyst consultant drafted a document entitled: "Behavior Protocol for Desensitization," which was the blueprint to use for dental visits for individuals who hesitated to enter the dental office. The use of edible rewards was mentioned, and the Dental Department commented to the consultant that this was not always an acceptable choice for dental treatment. The analyst provided other options for rewards, such as items the individual would have had an interest in, such as music, lotions, verbal praise, etc. The PST was to determine the best reward for each individual. The Dental Director discussed that this was a generic form. There was also the possibility of starting desensitization in the home, but this had not occurred at the time of the MT visit. Individual #242 had a Behavioral Protocol for Desensitization program implemented on 5/20/10. However, no data was available at the time of the Monitoring Team visit. On 6/18/10, the Dental Director requested assistance from psychology for four individuals, including Individual #387, Individual #276, Individual #548, and Individual #168. One of the individuals on the request list, Individual #244, had moved to a group home. There was some miscommunication or confusion between the Dental Department and the psychology department. The Dental Department was sent desensitization plans for individuals not requested, and had not gotten a response on names that were requested by the Dental Department. Part of the confusion was the Dental Department's list of names needing desensitization was different from the Medical Department's list of names needing desensitization. Some of those who had not cooperated with the Medical Department had been successful in cooperating with the Dental Department. Chemical sedation was used for approximately 55 individuals prior to the dental visit. From the "restraint and sedation tracking list," there were four individuals given sedation in March 2010, three individuals in April 2010, six individuals in May 2010, and	

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		nine individuals provided chemical sedation in June 2010. Common orders for chemical sedation included two to four mg Ativan, 1000-2000 mg Chloral hydrate, Halcion, or a mixture of Ativan 2 mg, Benadryl 50 mg, and Chloral hydrate 2000 mg. By state dental board rules and regulations, sedation of children was not given in the home unit, but in the office. In the office, it appeared that the minimal amount of sedation to be effective was utilized. The individual usually remained sufficiently alert to be engaged in conversation, and this had the added side effect of building confidence in the individual with the dental visit. If they were heavily sedated, then positioning became critical. The dental staff determined the position or posture where they had the best airway, and kept them in that position until the exam and procedure were completed. The OT department developed photos of the individual for optimal feeding position, and the Dental Department used the photographed position. The development of photos of optimal positioning was of great value to the Dental Department. There was a dental restraint and sedation tracking list/log for each month, which reported sedation used (type and dosage), types of restraints used, procedure, date, and whether effective. It is recommended that additionally, there should be a log of this same information per person, so that the dentist is then able to determine the next most efficacious medication at the lowest effective dosage for the procedure being planned. This would be a long-range historical log that would be valuable in identifying any trends in use of medication, and would be an excellent tool for planning a reduction in chemical or mechanical restraint use. Two months of the year, April and October, were scheduled so that individuals normally on sedation were brought over to the office to see what could be accomplished without sedation. This allowed the Dental Department to determine who had made progress in cooperativeness and who still required sedation. Physical/mechanical restraints were used with approximately 70 individuals. Three individuals required physical restraints in March 2010, two individuals required mechanical restraints in April 2010, six required physical and/or mechanical restraints in May 2010, and nine individuals required physical and/or mechanical restraints in June 2010. Physical restraints generally involved holding the individual in position with one's hands. Mechanical restraints included wristlets, and Velcro straps to the dental chair. The dental chair was an old oral surgery chair, and likely instilled some fear in the individual when the chair was seen. To reduce the use of restraints, it is recommended that a contemporary dental office chair with sweeping curved supports be purchased. It would tend to have the opposite effect of the current dental chair used.	

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		The dental office was creative in using a number of environmental measures to reduce anxiety and produce cooperation, so as to lessen restraint use. A couple of examples were provided. These included relaxing music, and the individual also was encouraged to bring his or her own music with them to play. Staff also spoke softly. To meet the needs of individuals with dysphagia, the Dental Department used a Steridentand Vacuum tooth-brushing procedure. According to the "ABSSLC Steridentand Vacuum Tooth-brushing Policy," revised July 2010, the purpose focused on decreasing the risk of aspiration during oral hygiene in persons, who were at risk of aspiration, had a history of aspiration, and/or were aspirating silently. The procedure required a physician's order, PST approval, and Occupational Therapy or Speech-Language Pathology recommendation to the PST. There also was a protocol concerning "Instructions, Use, and Care for Steridentand," dated 9/10/09. The dental office kept a list of those identified by the NMT as meeting the criteria for Steridentand tooth brushing. The criteria was expanded to include those individuals that "cannot manage thin liquids safely, people that cannot spit, and/or people that cannot brush independently." Criteria were used for both edentulous individuals as well as those with teeth. Records were reviewed to verify if Steridentand tooth brushing was being recommended and offered to qualifying individuals: Individual #431, Individual #281, Individual #100, and Individual #322. All four of the records (100%) had orders. Everyone on campus was considered at risk for aspiration, from the Dental Department's perspective. This had ensured they were careful in each case. The Dental Department was generally hesitant to sedate the individuals, according to the Dental Director. The Dental Department used a spreadsheet that listed all those who used sedation, the medication and dosage administered, and the procedure. Initially, the Dental Department did not request sedation based on one failed appointment. If the individual was not cooperative, the Dental Department observed it could take two to three appointments before seeing cooperation, which decreased the need of starting sedation. If the individual was on the missed appointment list repeatedly, and there was no progress with cooperation, then sedation was considered. Rather than conscious sedation being used in select cases, the Dental Department used the services of a dentist anesthesiologist. The gas anesthesia used was Ultane. Risks were considered lower with the use of Ultane than with IV sedation. In addition, there was less nausea, and the individual awakened quicker than with conscious sedation. General anesthesia had been used at ABSSLC since 1980, and there had been no adverse events of significance. When individuals were released from the dental office, they were	

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		monitored in the Infirmary for approximately three to four hours. For more extensive procedures, such as full mouth extractions, the individual remained overnight in the Infirmary. In the Infirmary, the individuals were monitored for alertness as well as vital signs. There was completion of a restraint checklist form every 20 minutes, and this information was to be transferred to the progress notes. Communication to individuals' PSTs was ongoing. One aspect that was highly instructive to the team was the determination of the level of oral hygiene and potential impact as a risk factor for pneumonia. The dental notes in the medical record on the following individuals were noted to have such comments: Individual #431 on 3/25/10, Individual #322 on 3/4/10, Individual #511 on 5/4/10, and Individual #294. The Dental Department had developed a major preventive dental care program involving oral hygiene. With two dental hygienists on staff, there was been the ability to promote this program. The number of dental cleanings doubled, which had an impact in several areas: individuals were more inclined to brush their teeth when there was less bleeding, and staff were less hesitant and more apt to assist when there was less bleeding noted; also, there was less halitosis. There was considerable oral hygiene instruction given to the staff by PowerPoint and demonstration. There had been training of both new staff and retraining of direct support professionals. There were also in home follow-up visits by the dental hygienist to provide further assistance with the home staff in training and brushing techniques. The dental hygienists screened 111 individuals for effective oral hygiene. Of these, forty individuals were selected to start the program. A training frequency of three days per week occurred with the individual in the home, with the focus on tooth brushing. For each of these individuals, training goals and objectives were developed. These were taken to the PSP addendum meetings for approval to start the oral hygiene training. For recording of progress, training sheets documented goals and objectives and what was accomplished each session. Each level was repeated up to six times and then the individual was moved to the next goal. There were 14 goals listed on the "Objective List of the Training Documentation Report," including such steps as to how to hold the toothbrush and how much toothpaste to place on the toothbrush. Individuals also were taught how to floss. One of the main steps was that the hygienist and trainer needed to keep reviewing each of the steps with the individuals. The dental hygienists were to review the weekly training records of the individuals. If there was no progress, then the plan was to be reviewed, and consideration given to revising it. At the time of the annual exam, there was a review of the oral hygiene by the dentist or dental hygienist. Based on this assessment, a new oral hygiene plan with goals was created.	

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		Documentation was requested to verify and clarify this new process. All individuals reviewed were at the initial phase of this program. The following individuals had information submitted: ▪ Individual #534 had training documentation reports from June to August 2010, a PSP Addendum with the decision that the PST agreed with the implementation of the training skill for dental hygiene, and personal support team signature sheet including the dental hygienist. ▪ Individual #237 had program documentation that included a resident skills evaluation (checklist for individualized oral hygiene training program development), a training document report for June 2010 to July 2010, and personal support team signature sheet including the dental hygienist. ▪ Individual #442 had a resident skills evaluation (checklist for individualized oral hygiene training program development), training documentation report for June 2010 through August 2010, and a personal support team signature sheet including the dental hygienist. In each of these cases, the program was just starting. Not any one resident's submitted record was complete, but did reflect a thorough and well-structured program. This program has immense promise for preventive dentistry potential, with the reduction of restraint use due to reduction in dental pathology from the result of improved Oral Hygiene Index scores.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State Office may need to seek guidance from the state medical society/association concerning additional steps needed to successfully recruit a full-time dentist to ABSSLC.
2. Concise definitions should be developed for each category of missed appointments in order for the data to be valid for analysis.
3. The Dental Department should create a brief communication to the home at the time of missed appointment requiring a written statement for the reason for the missed appointment, along with a signature of the staff responding.
4. More than one set of vital signs should be taken when pre-treatment sedation is administered on the home unit. The system is encouraged to review the frequency of recorded vital signs and other monitoring to verify it is occurring at an acceptable rate, and, if not, to increase the frequency of vital sign monitoring to ensure the medication is having the intended effect but not an adverse effect.
5. When pre-treatment sedation is given, consideration should be given to having a licensed staff accompany the individual during the time of transport to the dental office.
6. The dictation system the Medical Department uses should be expanded and be used by the dentist(s).
7. The reduction of chemical and physical restraint use in the dental office should be a priority.
8. In addition to a sedation log per month, there should be a sedation log per person, to determine chronologically, the medication and dosage and effect on the person over time, in order to begin to consider medication dosage reduction for pre-treatment sedation.
9. Replacing the current dental chair with a modern design would likely help in reduction of anxiety of the individuals as they approach the chair.

10. The Dental Department should meet at intervals with the psychology department to begin to develop desensitization programs and/or other strategies that would assist individuals who have difficulty in tolerating dental appointments without the use of sedation or restraint. Such plans should be to be specific to the individual interfacing with the Dental Department. A series of meetings may be more productive than a series of emails in promoting progress.
11. Additional dental policies need to be developed and implemented that comprehensively address the provision of dental care.

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Habilitation Therapies Manual, revised 5/13/10; o Speech Alternative Augmentative Communication (AAC) and Environmental Control Units (ECU) Equipment Spreadsheet and Monitoring List for multiple individuals, dated 6/10 and 7/10; o Assessment forms, including: Speech-Language Evaluation: Communication Adaptive Equipment (blank), dated 11/03; Annual Review (blank), dated 9/77; Evaluation (blank), dated 9/77; Evaluation-Update (blank), dated 9/77; Adapted Environmental Control Evaluation/Speech-Language Pathology (blank), dated 6/97; Speech-Language Evaluation/Adapted Environmental Control (blank), dated 6/97; Modified Barium Swallow Results (blank), dated 4/95; o OT/PT Annual Evaluation for multiple individuals, 12/09 through 7/10; o Personal Support Plans (PSP) for multiple individuals, 11/08 through 6/10; o Speech-Language Evaluation for multiple individuals, 6/09 through 6/10; o Analysis of Monitoring of Speech (AAC) Equipment, dated 7/25/10; o Communication Dictionary for multiple individuals, 6/09 through 6/10; o List of individuals receiving Direct Speech Services, not dated; o Service Plan/Speech-Language Pathology for multiple individuals, 5/09 through 6/10; o Training Documentation Report, 9/09 through 6/10; o Speech Language Pathologists Caseloads, dated 8/10/10; o Speech Language Pathologists Responsibilities, not dated; o Analysis of SLP Staffing Needs at ABSSLC, dated 3/10/10; o Speech Alternative Augmentative Communication (AAC) and Environmental Control Units (ECU) Equipment Spreadsheet and Monitoring List for June, July and August 2010; o Presentation Book Section R; o The following documents requested: SLP Assessment, SLP Updates, SLP Progress Notes for programs, SLP Communication program, PSP and PSP Addendums for the past year, Behavior Support Plan (BSP), SLP consultations for the past year; list of current equipment, competency-based training for SLP programs, Person-specific communication monitoring for June-July 2010, and PSP communication objectives/programs, for the following individuals: Individual #393, Individual #517, Individual #92, Individual #455, Individual #274, Individual #465, Individual #458, Individual #287, Individual #160, Individual #63, Individual #83, Individual #409, Individual #341, and Individual #14; o Section R Presentation by Cheryl Balanay, Speech/Audiology Director; and o Communication Dictionaries: Individual #517, Individual #540, Individual #328, Individual #43, Individual #437, Individual #479, Individual #110, Individual #455, Individual #276, Individual #505, Individual #293, Individual #153, Individual #313, Individual #310, Individual #287, Individual #439, Individual #160, Individual #525, Individual #324, Individual #297, Individual #246, Individual #11, and Individual #392

	▪ **Interviews with**: o Cheryl A. Balanay, MA, CCC-SLP; o Debralea Sessions, MS, CCC-SLP; o David Feemster, MA, CCC-SLP; o Melissa L. Fitzgerald, MS, SLP; and o Leslie Riggins, BBS ▪ **Observations of**: o Observations in homes 5961, 5962, 5971, 5972, 6330, 6460, 6450, 6700, 6690, 6521, 6350, 5972, 6500, 6370, and 6480; o Observations in Vocational and Activity Centers; and o Observations in Speech Language Pathology Clinic
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for ABSSLC did not include this component, the POI for Section R identified compliance and/or non-compliance with identified indicators. ABSSLC's POI indicated the Facility was in compliance with some of the indicators in Section R. However, based on the Monitoring Team's review, the Facility was not in compliance with the requirements of the SA. Status of compliance for each of the Settlement Agreement requirements, including individual examples supporting the determination of non-compliance are provided below. Examples of indicators that the Facility rated as being in compliance, but noncompliance was documented by the Monitoring Team included: Section R.1.5 documented compliance with the indicator: "100% of records reviewed show that supports are provided to individuals based on need and not staff availability." The Monitoring Team's observation and record review did not support compliance with this indictor. Section R.2.4 documented compliance with the indicator: "100% of records show that the SSLC will use a system-approved evaluation tool to identify individuals for communication needs." The Monitoring Team reviewed evaluations that did not include further assessment and/or investigation of AAC. Section R.2.11 documented "100% of records reviewed show that the findings of comprehensive assessment drive the need for further assessment in augmentative communication." The Monitoring Team did not concur with this compliance status for this indicator.
	Summary of Monitor's Assessment: There were 452 individuals living at ABSSLC. At the time of the review, the caseloads for speech language pathologists and speech assistants would not allow therapists to be active members of the individual's PST, or provide adequate functional communication supports. It appeared that a number of individuals who did not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they had not been assessed, and/or plans developed to meet their needs due to inadequate staffing levels. Even for individuals for whom recommendations had been made regarding communication, these were not integrated throughout their

	PSPs to make communication a functional part of their 24-hour day. There was a lack of collaboration between the psychology and speech/communication departments. As a result, concerns were raised regarding communication techniques that were either missing from PBSPs, or ones that might have been contraindicated. Generic communication devices were available in many locations on campus. Unfortunately, individuals and staff did not access these to support functional communication. There needs to be a system of oversight and monitoring to ensure that all individuals have a means of communicating their basic wants and needs.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>R1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.</td><td><u>The Facility provides an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. Training should include augmentative and assistive communication.</u>
There were 452 individuals living at ABSSLC. The following chart represented the current caseloads of the Speech Language Pathologists (SLPs):

<table>
<tr><th>SLPs</th><th>Current Caseloads</th></tr>
<tr><td>SLP #1</td><td>Department Head for Speech and Audiology and responsible for homes 6500 and 6390, serving 48 individuals</td></tr>
<tr><td>SLP #2</td><td>Responsible for homes 6480, 6330, 6370, 5971, 5972, 6450, and 6460, serving 143 individuals</td></tr>
<tr><td>SLP #3</td><td>Nutritional Management Team Coordinator and responsible for homes 6400, 6690, 6710, 6720, 6730, 6740, 6750, and 6760, serving 120 individuals</td></tr>
<tr><td>SLP #4</td><td>Responsible for homes 6350, 6360, 5961, 5962, 6700, 6510, and 652, serving 142 individuals</td></tr>
</table>

The SLPs were responsible for full evaluations and updates, new admission evaluations, Modified Barium Swallowing studies, Modified Barium Swallow study follow-ups, staff in-services, mealtime evaluations, 24-hour Choking Hotline pager and follow-ups, PNMP Clinics, and extended Nutritional Management Team responsibilities including chart review, meal observations, and event coverage. The SLPs completed an analysis of SLP staffing needs at ABSSLC, which identified the number of individuals, homes, and hours needed to ensure active participation as a member of an individual's Personal Support Team. These responsibilities included:
▪ Annual Personal Support Plan (PSP) meeting;</td><td>Noncompliance</td></tr>
</table>

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		▪ Personal Support Team monthly meetings; ▪ Choking Hotline, including response to serious incidents and follow-up; ▪ Modified Barium Swallow studies including attendance, development of report, and follow-up; ▪ Annual evaluations and updates; ▪ Evaluations for new admissions, updates and status changes; ▪ Behavior Support Committee (BSC) participation; ▪ Collaboration with psychologist in development of individual Behavior Support Plan (BSP), particularly with regard to the integration of functional communication; ▪ Direct therapy; ▪ Diagnostic trials including AAC equipment; ▪ Monitoring of communication objectives/programs; ▪ Modeling, in-servicing; ▪ PNMP Clinic; ▪ Mealtime evaluations; ▪ Case and progress notes; ▪ HST meetings, including preparation; ▪ NMT meetings, including preparation; ▪ Updating communication dictionaries; and ▪ Wheelchair evaluations. This analysis identified the need for nine full-time SLPs to meet the needs of individuals at ABSSLC. At the time of the review, the caseloads for speech language pathologists and speech assistants would not allow therapists to be active members of the individual's PST, or provide adequate functional communication supports. As was noted with regard to Section D of the SA, SLPs were responsible for conducting formal investigations for serious choking incidents. It was unclear why Facility Investigators did not complete these investigations. Given the other responsibilities of the SLPs, a recommendation has been included above with regard to Section D for SLPs to be consulted by Facility Investigators and/or used as expert witnesses, when technical issues related to a choking incident need to be interpreted by an Investigator. Clinical instruction completed by the SLPs and Speech Assistant for the past 12 months showed attendance at the following conferences and/or courses: Habilitation Therapies Conference, Issues in Nutritional Management, Introduction to Autism State Curriculum, Moving Toward Standardizing Dysphagia Practice: Introducing the Modified Barium Swallow Impairment Profile, Pediatric Dysphagia, and Teaching Children with Developmental Disabilities to Speak: Current Research and Best Practices. This continuing education did not provide ongoing specialized training to enhance skill	

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		development in augmentative and alternative communication. Therapy staff should be attending a variety of continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports to individuals living at ABSSLC. <u>Communicative Aiders and Speech Generated Devices (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC, receive AAC. SLPs actively participate in all facets of care in which communication is relevant.</u> Seven of the 14 records reviewed (50%) indicated individuals with identified language difficulties were receiving active speech treatment and/or participating in a speech program. The records reviewed included those for: Individual #393, Individual #517, Individual #92, Individual #455, Individual #274, Individual #465, Individual #458, Individual #287, Individual #160, Individual #63, Individual #83, Individual #409, Individual #341, and Individual #14. Based on this review, 7 of 14 records (50%) showed that Speech Language Pathologist(s) were actively involved in the care of individuals with identified speech/language and behavioral difficulties. It should be noted that 8 of 452 individuals (2%) living at ABSSLC were receiving direct speech services, including Individual #455, Individual #92, Individual #63, Individual #83, Individual #280, Individual #409, Individual #274, and Individual #160. All of these individuals were included in the record review with the exception of Individual #280. The following individuals were not receiving direct therapy services from a SLP. If SLP supports had been provided, these supports needed to be reinforced through skill acquisition programs in their PSPs: ▪ Individual #393's SLP Communication Adaptive Equipment Evaluation, dated 4/21/10, documented the use of a Picture Exchange Communication System (PECS) for "indicating leisure choices/preferences," but there was no formal speech program written for the use of the PECS. ▪ Individual #517's BSP, dated 7/1/10, instructed staff to "if you are having difficulty understanding [Individual #517] prompt him to use his Franklin Talking Dictionary and write what he is trying to say so that you can better understand him." The Communication Adaptive Equipment Evaluation, dated 3/8/10, recommended the team consider formal programming for the use of the Franklin Talking Dictionary. Individual #517 was not receiving direct speech treatment or participating in a speech program. ▪ Individual #465's SLP Evaluation Addendum, dated 7/20/04, stated: "direct speech/language therapy is not indicated as [Individual #465] still requires	

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		consistent ongoing input before she will be able to utilize a communication book expressively. These needs can best be met in the context of her daily living activities." Individual #465 did not receive a comprehensive SLP evaluation to assess her current strengths, interests and potentials for functional communication. ▪ Individual #14's Speech Language Evaluation, dated 1/7/04, indicated the SLP "will be available to provide in-service and assist in planning appropriate communicative programming as requested by the program manager." Individual #14 was not receiving direct speech therapy, nor was he participating in a speech program.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	<u>All individuals in need of AAC are identified as being in need of AAC.</u> Seven of 14 records reviewed (50%) indicated individuals identified with severe expressive/receptive language did not have AAC investigated and assessed. Examples of individuals diagnosed with severe language difficulties where AAC was not assessed or investigated, included: ▪ Individual #458's SLP Evaluation, dated 6/21/10, indicated that "formal testing was not needed at the current time because it was updated 10/15/08 and remains accurate." Individual #458 used a Single Switch Sequencer (speaking device) and a communication book. It was recommended that the "team consider a home objective for Individual #458 to look at and point in the direction of pictures (with her fist) in her communication book to make choices. The SLP will be available to provide in-service and assist in planning appropriate communicative programming as requested by the program manager." Individual #458's current evaluation did not assess and/or investigate AAC. ▪ Individual #287's SLP Addendum, dated 2/8/08, did not assess and/or investigate AAC, but current findings in the SLP addendum documented "she communicated by pointing, signing and physically manipulating the examiner. She also said 'no!' very clearly. She followed simple verbal instructions accurately without visual or contextual cues." It was unclear given these findings of her communication strengths and abilities that AAC should have been, but was not assessed or further investigated. <u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u> None of the four records reviewed of individuals newly admitted (0%) showed individuals had received screenings, assessments and reassessments as indicated upon admission, readmission, or change in status. Specifically, Individual #455, Individual #79, Individual #102 and Individual #328 were new admissions to ABSSLC, but had not received a SLP evaluation within 30 days of admission.	Noncompliance

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		Communication Assessment addresses: ▪ Both verbal and nonverbal skills; ▪ Expansion of current abilities; ▪ Development of new skills; ▪ Whether the individual requires direct or indirect Speech Language services; and ▪ The need for further assessment in Augmentative Communication. In the 7 records reviewed (Individual #393, Individual #517, Individual #92, Individual #455, Individual #274, Individual #465, and Individual #458), the Communication Assessment assessed the following areas: ▪ In 3 of 7 records, reviewed (43%), the assessment addressed verbal and nonverbal skills. ▪ In 3 of 7 records reviewed (43%), the assessment addressed expansion of current abilities. ▪ In 3 of 7 records reviewed (43%), the assessment addressed development of new skills. ▪ In 3 of 7 records reviewed (43%), the assessment addressed whether the individual required direct or indirect Speech Language services. ▪ In 0 of 7 records reviewed (0%), the assessment addressed the need for further assessment in Augmentative Communication. Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP. None of the 7 records reviewed (0%) for individuals with goals/objectives related to language acquisition (Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409), had goals/objectives/outcomes written and followed by the SLP on a monthly basis if service was direct, and quarterly, if indirect. For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. The Communication Services policy, dated 10/7/09, Section II.D Assessment stated: "Assessments will consider the behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions." The policy did not provide additional information beyond this statement. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals	

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		with challenging behaviors, including collaboration with the individuals' psychologists and PSTs. <u>Communication programs are integrated into the PBSP as indicated.</u> None of the 7 records reviewed with Behavior Support Plans (Individual #517, Individual #455, Individual #274, Individual #465, Individual #287, Individual #160, and Individual #63) (0%), indicated integration of the communication program and the PBSP. Examples of individuals with identified communication difficulties whose plans were not integrated in the PBSP included: ▪ Individual #517's BSP, dated 7/1/10, indicated staff were to prompt the use of his Franklin Talking Dictionary, but he did not have a formal speech program. There was no evidence that his SLP collaborated in the development of his BSP, and he did not have a formal speech/communication program. ▪ Individual #445's BSP, dated 5/7/10, documented the use of his PECS communication system, but there was no evidence to support SLP collaboration in the development of his BSP. Individual #445's Service Plan, dated 5/7/10, documented Individual #445 "will receive speech-language activities once or twice a week to facilitate the development of an augmentative communication system for him to use through his daily schedule." No formal speech/ communication program was submitted. ▪ Individual #274's BSP, dated 1/12/10, did not document collaboration with a SLP, although his BSP identified a plan for teaching replacement behaviors for communication training and the use of a PEC system Additional concerns were noted with regard to the integration of communication strategies and PBSPs. A review of 23 Communication Dictionaries was completed. These offered a summary of the individual's means of communication and described other behaviors that may serve a communicative function. An example of gestures used to indicate presumed communication was found for Individual #479. In several cases, the hypothesized function was in agreement with the information found in the individual's Behavior Support Plan (e.g., Individual #455). In other cases, the function of the observed behavior was described as an indication that the person was mad, unhappy, frustrated, or anxious (e.g., Individual #313, Individual #310, Individual #287, Individual #525, Individual #324, and Individual #392). These descriptors of emotional states did not provide a clear understanding of the function of the behavior, and might impede the development of more appropriate behavior. It would be helpful if a clearer understanding of the function of the behavior could be obtained, working in conjunction with the psychology and direct support professionals, so that more appropriate, alternative means of communication could be taught to the individuals.	

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		There also was concern with regard to the guidelines provided to staff. In several cases, the advice given to staff about how they should respond might, in fact, reinforce undesirable behaviors. For example, Individual #525 was noted to yell, scream, grab, and bite. Staff were directed to try to figure out what was wrong and help him to solve the problem. Individual #297 was reported to attempt to hit or bite, and staff were again advised to help find out what was wrong to help solve the problem. Individual #392 was reported to scream and hit herself. Staff were directed to ask her if she wanted to go to another room, sit near a window, or listen to country music. There is a risk that any of these staff responses could reinforce the problem behavior. A more appropriate approach would be to design teaching programs to help the individual learn a more adaptive way to express his/her wishes and needs. <u>Policy exits that outlines assessment schedule and staff responsibilities.</u> A policy did not exist that outlined the assessment schedule and staff responsibilities. The Communication Services policy, dated 10/7/09, Section II. Assessments stated: "comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." ABSSLC did not have a Master Communication Plan for the prioritization and implementation schedule for SLP assessments. Procedures needed to be developed to provide consistency in the implementation of SLP assessments. At the time of the review, SLP evaluations reviewed did not follow the established format in Habilitation Therapies Handbook Physical and Nutritional Management, revised 2009.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the 14 records reviewed (Individual #393, Individual #517, Individual #92, Individual #455, Individual #274, Individual #465, Individual #458, Individual #287, Individual #160, Individual #63, Individual #83, Individual #409, Individual #341, and Individual #14) (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: ▪ Individual #393's PSP, dated 5/19/10, in the Section for Assessments/Services the Person Uses/Needs identified four recommendations. These recommendations did not present the rationale, nor were they integrated into the body of the PSP. In addition, the SLP did not attend the PSP meeting. ▪ Individual #455's PSP, dated 4/27/10, in the Assessment/Services the Person Uses/Needs section identified recommendations, communication equipment, and communication/active treatment instructions. Also, within this section, it was documented that he would receive speech-language activities once or twice	Noncompliance

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		a week to facilitate the development of an augmentative communication system for him to use throughout his daily schedule. His SLP did not attend the annual PSP meeting. Individual #455's communication strategies were not integrated into his PSP. ▪ Individual #274's PSP did not integrate his communication strategies into the overall plan. He had a Service Plan for speech pathology that indicated: "at least once a week [Individual #274] will receive speech-language intervention in the form of direct treatment or opportunities to practice using a picture exchange communication system." He did not have a formal communication program. His SLP therapist did not attend his annual PSP. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the 14 records reviewed in which communication interventions were referenced in the assessment section of the PSP had evidence of integration of the individual's methods for expressive receptive communication, as well as strategies for use by staff integrated throughout the document as well as in other programs such as PBSP, day program, skills training on the home, in leisure activity program plans, etc. For example: ▪ Individual #393's PSP, dated 5/19/10, in the Assessment section documented communication interventions, but these strategies were not integrated into the PSP's Action Plans. ▪ Individual #14's PSP, dated 3/25/10, in the Assessment section documented language/modality preference and communication instructions, but these strategies were not integrated in his Action Plans. <u>AAC devices are portable and functional in a variety of settings.</u> None of the seven Service Plans reviewed with an AAC component (0%) reinforced the use of AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, ADLS). Examples of Communication programs that did not contain AAC equipment that was determined to be functional or portable in a variety of settings included: ▪ Individual #92's augmentative communication device was not mounted on her chair during an observation in her home. The Service Plan indicated: "will receive speech-language services in the form of direct treatment or opportunities to practice with her communication book and augmentative communication voice computer at Speech-Language Pathology." The Service Plan did not address strategies for the use of her communication equipment in a variety of settings. ▪ Individual #455's Service Plan, dated 5/7/10, stated: "will receive speech-	

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		language activities once or twice a week to facilitate the development of an augmentative communication system for him to use throughout his daily schedule." The Service Plan did not identify strategies to support the use of his PECS in his daily schedule. The PSP did not integrate communication strategies, nor did his SLP attend his annual PSP to collaborate with team members in supporting functional communication throughout the 24-hour day. ▪ Individual #160's Service Plan Speech-Language Pathology, dated 3/3/10, stated: "will receive speech language activities once or twice a week to facilitate use/continued development of an augmentative communication system for him to use to clarify his speech and sign language and he will work on enhancing his speech. Therapy will focus on following directions." The PSP, dated 3/3/10, did not integrate his communication strategies, nor did his SLP attend the annual meeting. <u>AAC devices are individualized and meaningful to the individual.</u> None of the seven records reviewed (0%) included adequate descriptions of the ways in which the AAC devices would be made functional and meaningful to the individual to improve his/her daily living. Service Plans for Speech-Language Pathology for the seven individuals reviewed were not formal communication programs with individualized strategies for each individual's AAC device. The Service Plan components included a statement addressing what was to be accomplished, status, staff responsible, strategy and estimated completion date. A communication program had not been developed for use by staff to reinforce what was being learned in direct therapy. For communication skills presented in direct therapy to be functional and meaningful to the individual, these skills need to be incorporated into multiple skill acquisition programs, as well as practiced through informal teaching opportunities throughout multiple natural environments in the home, at work and during leisure activities. <u>Staff are trained in the use of the AAC.</u> None of the 7 records reviewed for individuals with Service Plans (0%) (Individual #92, Individual #455, Individual #274, Individual #160, Individual #63, Individual #83, and Individual #409), included competency-based staff training documentation. Moreover, there were no formal communication programs (for staff use to reinforce what was being learned in direct SLP therapy sessions) documented in the 14 records reviewed, even though seven of these individuals had Service Plans and were receiving speech therapy services. <u>Communication strategies/devices are implemented and used.</u> In none of the nine observations (0%) did staff implement interventions and	

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		recommendations outlined in speech recommendations. Examples of individuals where staff did not implement a communication program as written included: ▪ During an observation in Individual #465's home, it was noted that her communication book remained at home while she attended day programming. ▪ Individual #287 had a communication book, but staff nor Individual #287 were using it. ▪ Individual #377's accessed a switch that triggered a request, but staff did not respond to her request. ▪ Individual #458's staff were working to implement a program using a switch that was not functioning. ▪ Individual #14's had a communication device mounted to the back of his chair for staff use, but it was not accessible to Individual #14. ▪ Staff stated that Individual #274 "hardly uses his PECS book," but his Service Plan had not been revised to address his lack of use with his PECS. ▪ Individual #280 was observed in the workshop with his PEC notebook. Staff had not been trained on the system, and there were no directions for staff to reference. ▪ Individual #63 was observed in her bedroom during a visit from her mother. She could not access switch to turn on the radio mounted on her seating system. <u>General AAC devices are available in common areas.</u> Observations in 14 homes confirmed that general AAC devices were present in the Common areas. None of the observations in these 14 homes (0%) demonstrated that staff utilized common area AAC devices.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a	<u>Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.</u> There were no policies/procedures submitted to define the current speech (AAC) equipment monitoring process. The Speech Alternative Augmentative Communication (AAC) and Environmental (ECU) Equipment Spreadsheet and Monitoring List identified by home individualized communication and environmental control units and general use home equipment. The monitor documented the date and shift of the monitoring observations. Monitoring fields included "in place," "found," "missing," "monitored home," "SLP evaluation driven," "general use," "work order," and "repair needs/other issues/needs." Per report, an	Noncompliance

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	manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	analysis was completed of previous speech (AAC) equipment on 7/25/10, which stated "over the past two years the number of items that are found and out where they are supposed to be has improved. Use of equipment remains less than 10% by snapshot." An action plan was submitted with the following steps: ▪ "New monitoring tool is being developed which will score each home with percentages; ▪ Will coordinate with QE to trend and track these results; ▪ Each month's results will be reported to Unit Directors (UDs), Home Supervisors, Assistant Director of Programs and Director of Speech Department; ▪ Work with UDs on importance of equipment being out and in use and need for expectation of supervisors; ▪ Teach shift leaders importance of equipment being out and in use; and ▪ Plan to utilize one PNMP Coordinator to assist in this area as communication equipment is part of PNMP." A review of 14 individual monitoring reports (Individual #393, Individual #517, Individual #92, Individual #455, Individual #274, Individual #465, Individual #458, Individual #287, Individual #160, Individual #63, Individual #83, Individual #409, Individual #341, and Individual #14) documented that staff were not being monitored in all aspects of AAC utilization. This included: ▪ In 14 of 14 monitoring reports reviewed (100%), the presence of the ACC was documented. ▪ In 0 of 14 monitoring reports (0%), the working condition of the AAC was addressed. ▪ In 0 of 14 reports reviewed (0%), the implementation of the device was addressed. ▪ In 0 of 14 reports reviewed (0%), the effectiveness of the device was documented. <u>Monitoring covers the use of the AAC during alls aspects of the person's daily life in and out of the home.</u> In reviewing the individual monitoring reports for 14 records, staff documented the shift when monitoring occurred, documented the equipment was "in place," but did not identify the place although it was assumed the monitoring was conducted in the individual's home. The current monitoring system did not review the use of AAC systems during all aspects of the person's daily life. The monitoring forms did not document if the monitoring took place in a variety of environments to support facilitation of the device across multiple settings. <u>Validation checks are built into the monitoring process and conducted by the plan's</u>	

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		author. As noted above, the current monitoring had not been developed and memorialized in policy, and, therefore, it was not clear that this validation process was in place.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State should provide supports to the Facility to recruit and hire to fill the SLP vacancies at ABSSLC.
2. The Facility should review the analysis of required duties developed by the SLPs to establish realistic caseloads for SLPs, and enable the SLPs to become functioning, active members of individuals' PSTs.
3. SLPs should be attending a variety of continuing education classes in augmentative and assistive communication courses to bring diversity of knowledge and skills to the provision of functional communication supports to individuals living at ABSSLC.
4. Procedures should be developed to provide consistency in the implementation of SLP assessments.
5. Individuals' communication strategies should be consistently integrated into their PNMPs and PSPs.
6. Speech and language department staff should continue working with psychology staff to ensure that functional communication skill strengthening and training is included in all Behavior Support Plans. Further, it is recommended that clear descriptions of replacement behavior be included in all of these plans.
7. All individuals who do not have effective means of communication should be assessed, and, as appropriate, provided with training objectives to address their needs. If augmentative devices are recommended, these should be individualized. All systems should provide the individual with a "voice" so that he/she can at a minimum make his/her basic wants and needs known.
8. The ABSSLC Management Team, in collaboration with the Speech Pathologists, should develop and implement a plan to support the implementation of generic and individual-specific communication systems across a 24-hour day. The Facility should consider identifying a home to pilot the development and implementation of functional communication systems across all environments. This would promote interdisciplinary planning, development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.
9. Policies/procedures should be developed for the communication monitoring system with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of the functional communication programs and equipment; staff utilization of generic AAC devices; fit, function, availability and use of AAC devices; and staff competency with regard to functional communication devices and programs. There should be established thresholds for staff re-training; identification, training and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Personal Focus Worksheet (PFW): Individualized Assessment Screening Tool; o Course Description: Person Directed Plans, PER0200; o Template for Personal Support Plan, dated 7/10; o Personal Support Plans for: Individual #387, Individual #267, Individual #415, Individual #517, Individual #540, Individual #328, Individual #61, Individual #437, Individual #479, Individual #530, Individual #455, Individual #276, Individual #505, Individual #481, Individual #486, Individual #398, Individual #149, Individual #287, Individual #439, Individual #260, Individual #102, Individual #324, Individual #246, and Individual #111; o Personal Focus Worksheets (Individualized Assessment Screening Tool) for: Individual #267, Individual #517, Individual #540, Individual #437, Individual #276, Individual #149, and Individual #246; o Training Documentation Reports for: Individual #23, Individual #25, Individual #415, Individual #230, Individual #534, Individual #4, Individual #361, Individual #29, Individual #528, Individual #244, Individual #156, Individual #485, Individual #455, Individual #411, Individual #48, Individual #443, Individual #243, Individual #350, Individual #533, Individual #278, Individual #322, Individual #79, Individual #167, and Individual #103; o Training Documentation Reports (including data) for: Individual #61, Individual #505, Individual #398, Individual #310, Individual #486, and Individual #287; o Abilene State School Comprehensive Functional Assessments for: Individual #61, Individual #505, Individual #486, and Individual #287; o Positive Adaptive Living Skills Assessment: Individual #540, Individual #398, and Individual #310; o Community Living/Discharge Plan for Individual #58; o PowerPoint presentation entitled "Teaching People with Developmental Disabilities," proposed by R. Manns and provided to J. Herrera; o Minutes from QMRP Meeting, held on 1/13/10; o QMRP Meeting Agenda, dated 4/20/10; o Training Skills Instruction Sheet, revised 6/8/10; o Guidelines for Documentation of Training Objectives, revised 6/8/10; o Copy of overheads used in staff training, "Guidelines for Training Objective (Skill) Documentation: Staying the Course," revised 6/10; o Training Skills Procedure – handout provided to home supervisors and unit directors; o Training Documentation Report (Hand washing) for Individual #486, dated 7/31/10; and o List of Homes by Unit

	▪ **Interviews with**: o Juan Herrerra, QMRP Coordinator ▪ **Observations of**: o Home 5961, Home 5962, Home 5971, Home 5972, Home 6330, Home 6350, Home 6360, Home 6370, Home 6390, Home 6400, Home 6450, Home 6460, Home 6500, Home 6510, Home 6690, Home 6700, Home 6710, Home 6720, Home 6730, Home 6740, Home 6750, and Home 6760; o Activity Center 5921, Activity Center 5922, Activity Center 5923, Activity Center 6340, and Activity Center 6380; o Senior Center 5911, Senior Center 5912, and Senior Center 5913; o Workshop 680, Workshop 662, and Workshop 657; o Personal Support Planning/Discharge Planning Meeting for Individual #58, on 8/3/10; o Personal Support Planning Meeting for Individual #303, on 8/5/10; and o Unit Meeting, on 8/4/10
	Facility Self-Assessment: The Facility's POI indicated that it was not in compliance with any of the components of Section S of the Settlement Agreement. However, the POI identified a number of actions that the Facility was taking to improve its development and implementation of habilitation, training, education, and skill acquisition programs. The QMRP Coordinator also summarized these in a presentation on progress that had been made. As presented by the QMRP Coordinator, the Facility had made efforts to address areas identified as in need of improvement. A pilot project had been introduced to improve the Personal Support Plan process. One component of this was the Personal Focus Assessment Worksheet, designed to help determine what was important to the individual in relationship to living, working, and leisure environments. As explained by the QMRP Coordinator, the goal was to complete the worksheet with the individual two to three months prior to the annual meeting. The information provided then would be used to guide further assessment. The QMRP Coordinator also had begun working with staff from the psychology department, particularly the Behavior Analyst, to ensure that training objectives reflected all necessary components. Further collaboration between these two departments was apparent in the draft outline of a new training program for staff in the area of teaching individuals with disabilities. The QMRP Coordinator also reported that he was working closely with the Active Treatment Coordinator to improve overall engagement of the individuals served. While the Facility identified each of the areas as out of compliance with the Settlement Agreement, efforts were underway to be in full compliance by June of 2011. The Monitoring Team looks forward to learning of the Facility's progress during the next visit.
	Summary of Monitor's Assessment: As noted in the baseline report, assessment of individuals' needs remained incomplete. While the Positive Assessment of Living Skills (PALS) had been introduced, only

	portions of this tool were used to assess current skill levels. This resulted in plans that were limited in scope. There had been some improvements noted in the Personal Support Plan documents, however, Training Documentation Reports continued to lack the information and degree of specificity needed to ensure effective teaching and resulting skill development. Activities provided in homes, treatment centers, and workshop areas continued to be very limited, often resulting in poor levels of engagement by the individuals served. Lastly, insufficient training was provided in more integrated, community-based settings.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	In total, 24 Personal Support Plans were reviewed. With the exception of four plans that were identified as part of a pilot project, each plan followed a similar format. The plan began with a review of the people, activities, and items that had been identified as important to the Individual. This was followed by a brief review of assessment results and services provided by different disciplines. A record was included of additional topics discussed, followed by a review of different living options. The final section referred to the individual's Action Plan for the upcoming year. In completing the review of these documents, concerns were raised regarding the assessments employed to determine the needs of the individual. This is discussed further below with regard to Section S2 of the SA. Due to incomplete or outdated assessments (e.g., Individual #267 and Individual #287), the adequacy of the habilitation and training services provided to an individual was questionable. In a few cases, the identified assessment was current, but "not applicable" was noted in lieu of recommendations (e.g., Individual #415). Further, in many cases, those skills that were to be addressed were often continued from the previous year or earlier (e.g., Individual #517, Individual #398, Individual #260, and Individual #324). While the rate of an individual's acquisition of a particular skill cannot be determined with full accuracy, when progress is not seen, or it is particularly slow, it is important that the program be reviewed carefully to ensure that the teaching methodology is effective in promoting progress. In addition, there were significant concerns raised regarding Action Plans. In no case (0%) were behavioral goals provided, as noted in the baseline report. For example, in the case of Individual #61, personal hygiene, shaving, money skills, eating, leisure, self-medication, and laundry were listed under Action Plan #5. There was no description of what the individual was learning, the conditions under which the skill was to be taught, or the criterion employed to determine skill mastery. Other examples of this problem	Noncompliance

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		were noted in the Plans for Individual #437, Individual #479, Individual #455, Individual #505, and Individual #287. Additional information that was supposed to be provided in the Action Plans included the responsible person, the frequency or due date, and place for documentation. In several plans, this information was missing or incomplete (e.g., Individual #540). The frequency of implementation was occasionally identified as "ongoing" (e.g., Individual #61 and Individual #479) or "as scheduled" (e.g., Individual #437 and Individual #530). In some of the more recent plans, implementation dates were noted as "when written," "when answered," or "when consultation answered" (e.g., Individual #328). It should be noted that the four plans that were part of an improvement pilot project included specific dates for objective implementation (e.g., Individual #481). Additional feedback regarding the skill acquisition/teaching plans for specific individuals is provided below: ▪ Individual #517, Individual #455, Individual #276, Individual #505, and Individual #246: All of these Individuals were identified as being at high risk for choking due to placing too much food in their mouths at one time and rapid eating. Consideration should have been given to teaching a slow eating routine to these individuals, but this was not indicated as having occurred in their plans. ▪ Individual #540: One goal was for her to engage in exercise by walking home from the Senior Center, yet there was a note that she did not like the Senior Center. This conflict potentially could result in limited opportunities for exercise. Concern also was raised related to mealtime behavior. This individual was noted to put her plate on the counter to indicate she was finished eating. Staff reported this as an unsafe practice, yet an alternative was not proposed to provide her a new skill that would increase her independence, while ensuring her safety. ▪ Individual #437: Under the communication section, staff were advised to ask Individual #437 to repeat himself if he could not be understood. It was only after he had tried twice to make himself understood that he was directed to use an augmentative system. This would appear to make communication only increasingly difficult for the individual and might result in his communicating less frequently, or displaying problem behavior in response to repeated instructions to verbally communicate. ▪ Individual #246: This individual was observed on at least five different occasions during the week. During all but one observation, he was outside, crouched on the ground, sifting dirt/sand from over his head onto his clothing. Staff reported that this was a highly preferred activity, and they do their best to keep him out of the sun and well hydrated. Unfortunately, there was no indication that staff were regularly offering him viable alternatives to this	

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		activity that had the potential to place him at risk, and in addition was not normalized. Although staff reported it as his choice, it did not appear it was an informed choice. It was not clear that he was being regularly offered other alternatives that addressed some of his preferences, but were safer and more normalized. Moreover, his PSP did not include any efforts to teach more appropriate leisure skills. Further, his Personal Focus Worksheet was largely incomplete. The information that was included was questionable with regard to its appropriateness and with regard to it being based on his choice versus staff's choice. For example, it was suggested that this individual "… may enjoy collecting coins or stamps, … may like a pet such as (a) dog or cat, (or) … could explore new opportunities such as dating." Activities listed under "What works, what's going well, and what needs to be maintained/enhanced," included "outside activities, hiking, hunting, and fishing." These activities all seemed unlikely when one considers the highly restrictive nature of his environment, his limited cognitive abilities and safety skills, and his apparent preference for isolated activities. Although it is beneficial to identify long-range goals, his PSP did not offer realistic alternatives to his current activity of sifting sand over his head. In this regard, his team had failed to provide him with adequate treatment. A total of 149 Training Documentation Reports, representing skill acquisition programs for 24 Individuals, were reviewed. The noted annual review date for 22 of these 24 Individuals was 2010 (10 in May, nine in June, three in April). As noted in the baseline report, most included steps for teaching the skill, a schedule for training, and designated days for data collection. Essential elements were still missing, incomplete, or unclear as written. The following should be considered as improvements to this system are made: ▪ Objectives did not indicate the behavior to be emitted by the individual, the conditions under which the behavior was to occur, and the criteria used to determine mastery. Examples included: a) Individual #23 who was to "choose between Gospel and Country" music, and staff were instructed to determine his choice by noting the music to which he "responds most calmly," but a calm response was not defined; b) Individual #230 was to "participate in an activity for 15 minutes," yet participation was not defined; c) Individual #411 was being asked to "continue working," yet there was no description of his observable and measurable behavior; and d) Individual #167 was to "identify her name on the med card/box," but the identifying response was not specified. ▪ Although training schedules indicated the day the skill was to be taught, it was unclear how often (i.e., how many times daily) training was to occur. ▪ The setting for training often was not specified. ▪ In no cases were there instructions for the collection of baseline measures. ▪ Teaching conditions that provided clear guidelines to the staff for ensuring	

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		successful acquisition of the identified skill were absent. Conditions should include the manner in which materials are presented, criteria for the use of prompts and fading of the same, guidelines for implementing chaining and shaping strategies, and specific information regarding instructor response to both correct and incorrect responses. ▪ In 135 cases, verbal or social praise/attention was identified as the reinforcer to be provided contingent upon responding. Of the remaining 14 reports, reinforcement was not identified in nine instances, the item to be purchased was identified in three cases, and an edible reinforcer was provided in one case. As noted previously, positive feedback is important whenever appropriate behavior occurs, yet, one must be cautious in assuming that praise or something similar will always function as a reinforcer. For example, in the case of Individual #455, reinforcers listed in his Behavior Support Plan included several food items and a few toys or activities. Verbal or social praise was not identified as a reinforcer, yet, it was the identified reinforcer in all six of his training objectives. ▪ Schedules of reinforcement were not identified. ▪ Absent from all Training Documentation Reports was planning for the maintenance and generalization of the skill. Additional concerns were raised during the review, including: ▪ In several cases (e.g., Individual #415, money skills and lotion rub; Individual #4, money skills and laundry; Individual #5, making a purchase; Individual #485, making a purchase, for which staff were advised that she could practice this skill, but must go to a store or the diner only once monthly; Individual #48, cooking; Individual #243, plan meal; Individual #533, money management; Individual #167, washing clothes and buying snacks; and Individual #103, making a purchase), the training schedule was limited to only one day per week. Other schedules were limited to twice weekly (e.g., Individual #25, grasp object; Individual #534, work; Individual #244, clean personal area and exercise; Individual #48, work and money management; and Individual #322, grasp object and money management). This limited exposure and opportunity to practice might severely compromise the individuals' ability to acquire a skill. ▪ Included in several programs was an objective list that appeared to provide a sequence of steps staff were to follow to teach a skill. In many cases, the individual was to first exhibit the target behavior in response to multiple verbal prompts. Each successive step included fewer and fewer prompts. These guidelines as written, will actually result in the learner learning to not respond to an instruction. For example, in the case of Individual #23, the first step in his mobility program was for him to move to the dining room with verbal prompts provided up to six times. This results in a "nagging" paradigm where the learner learns to ignore directions or instructions given. A better approach would be to	

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		shape the response by gradually increasing the distance the learner must traverse to reach the dining room, or to initially provide prompts to ensure the learner's success and then gradually and systematically fade these prompts to develop independence. Other examples included Individual #23 (self-medication), Individual #415 (prerequisite – self-medication), Individual #230 (exercise), Individual #4 (cleaning room), Individual #156 (personal hygiene), Individual #485 (work and communication book), Individual #455 (dressing, shower, self-medication, and tooth brushing), Individual #411 (responsible behavior), Individual #48 (work), Individual #533 (self-medication), Individual #322 (make a choice and money management), and Individual #167 (work). ▪ It also appeared that the steps outlined in the objective list were to be taught one step at a time. While this would be appropriate if the goal was to shape a behavior, concerns were raised when the steps described a behavioral chain. Unless the individual is given the opportunity to participate in all steps of the chain, the development of the chain is seriously compromised. ▪ Some objectives appeared to address a skill or an activity with which the individual had a prior negative history. In the case of Individual #23, he was learning to hold a ball (grasping object). Staff were advised that the individual "…may begin to yell and act agitated." This skill was identified as a pre-requisite to money management training, yet it clearly appeared to be an unpleasant or non-preferred activity for the individual. A suggestion would be to examine a more functional skill for the individual that may more directly relate to the use of money. Individual #415 had a goal "…to increase his tolerance for outside activities." He was to remain "calm" while outside. A check of his Behavior Support Plan indicated that music was a reinforcer. Perhaps he would be more amenable to outside activities if music were available to him simultaneously as long as he met the criterion for "calm" behavior. Individual #533 had an objective to increase his attendance at the Senior Citizens program. As reflected in the instructions section, he often refused to go or became aggressive when prompted to go. The activities provided at this center should be examined with consideration given to alternatives that would better address the individual's particular interests. Individual #4 had an objective designed to help improve her performance in the workshop. It might prove helpful to offer her a simple choice between two tasks and two staff with whom to work upon her arrival to the site. Both psychology staff and communication staff should participate in designing objectives that relate to problem behavior. ▪ Some skills might be better addressed by counseling staff (e.g., Individual #243, social interaction). One objective called for this individual to first recite rules for social behavior, including: a) "It's not okay to touch someone in their private areas;" b) "It's not okay to touch myself in a sexual way in front of anyone;" and c) "It's not okay to force myself on others." Once these were recited, he and staff	

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		were to engage in role-play to demonstrate appropriate ways of interacting. If this and similar objectives were to be addressed by direct service personnel, social rules should be stated in an appropriate way. Staff also should reinforce appropriate social interaction when it does occur. This will ensure that generalization of the skill to the community will result in the individual stating and hopefully practicing appropriate rules of social interaction. His learning to recite rules related to behaviors he should not exhibit will likely offend and possibly create discomfort and perhaps fear among members of his local community. ▪ There were several examples where it was unclear how the specific objective contributed to the development of the skill identified in the training statement. Individual #361 was learning to hold a coin or bill while smiling. It was unclear how this was teaching her to identify money. Individual #25 was to increase her socialization skills by accepting a massager. Individual #533 was to learn to point to various body parts to develop greater independence in the area of self-medication. As a pre-requisite to handling money, Individual #322 was going to learn to hold various items (a plastic fruit, popcorn ball, paper mache cone, vibrating pillow, and ball) for up to four and one half minutes. This same individual was expected to learn the value of money by pointing to the money indicated on a money bingo game. ▪ Objectives should be written so that there is an active response on the part of the learner, but this was not found consistently. Individual #23 had an objective to learn to make a choice, but there was no description of an active response other than calm behavior. Consideration should be given to his learning to operate the CD player independently. Individual #528 had an objective to teach her interaction skills. Fourteen steps were listed in the objective list, nine of which described staff behavior. This same individual had a communication skill program in which she was learning to make a choice. Although she was reported to be legally blind and did not communicate verbally, the first three steps involved her making a choice between books by smiling. It is unclear how the individual was able to discriminate between the choices provided. If staff were to describe the books, this was not stated. ▪ Two individuals had objectives related to time telling and math skills, respectively. Individual #4 was learning to tell time using an analog clock. If the goal of the program was to enable her to tell time, it might prove more effective and result in quicker learning if a digital clock was employed. Similarly, Individual #48 was learning to complete multiplication and division problems. Although he could check his work by using a calculator, he was learning the skill using paper and pencil. As many adults now use calculators whenever math skills are necessary, consideration should be given to teaching him to master the use of a calculator, so he can learn the skill more rapidly and progress on to	

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		more advanced and functional life skills. ▪ Individual #230 was reported to work all day. Once home, "she prefers to sit in her recliner, relax, and watch television." One objective was for her to participate in group activities for up to 40 minutes. Another was to increase her time exercising. It may be most appropriate to combine these two objectives to allow her to participate in a small exercise group during which she could watch television. ▪ Individual #534 was learning to manage her anger by stating rules. However, five of the six rules reviewed what she should not do. While there is value in learning appropriate social interaction skills, active steps to follow when angry might better address this individual's identified need. ▪ Individual #103 had an objective in which he was to learn to make a purchase at the Diner or a store located on the campus. What was concerning was that the instructions included the following: "…at any point if [Individual #103] starts getting upset and displays aggression, stop the training, and finish the purchase yourself and give him the item again telling him he bought that with the money he brought." Not only will this likely result in the individual not learning the skill, but it also will likely reinforce his aggressive behavior. ▪ Lastly, all plans should be reviewed to ensure that the correct name of the individual is used throughout. Similar to what was reported in the baseline report, measures of engagement were collected throughout the week. Planned Activity Checks (PLACHECK) were completed in homes, activity centers (including the Senior Center), and workshop areas. In the homes, a total of 24 PLACHECK measures were collected. The range in scores was zero to 100 percent, with an average of 21.08% engagement. In nine cases, none of the individuals served (0%) was actively engaged at the time of the observation. In one home, nine individuals were seated around one staff member who was applying paint to a model car. A total of 23 PLACHECK measures were collected in the activity centers. Here, engagement scores ranged from zero to 100 percent, with an average score of 15.61% engagement. During 12 of these observations, none of the individuals served (0%) was engaged. During one observation, five individuals were seated in front of a monitor, on which characters were displayed dancing to rock music. The two staff who were present were interacting with these women, moving about and encouraging them to move to the extent possible. A third staff member then entered the room, interrupted the song that was playing, chose a new song and spent the next several minutes following along to the dance steps. At no time did she interact with the individuals. The highest rates of engagement were found in the workshop areas. PLACHECKS ranged from 33 to 100 percent, with an average score of 80.17% engagement.	

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		Staff are encouraged to examine and expand the variety of activities available in all environments to ensure greater engagement among the individuals served. Particular attention should be paid to providing activities that are functional, age-appropriate, and of interest to the individual.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	A review of seven assessments was completed. Six of these assessments had been provided by the Facility as the most recent assessment for individuals living in different homes. Three of these were completed in 2008 (Individual #505, Individual #486, and Individual #287), one in 2009 (Individual #61), and two in 2010 (Individual #398 and Individual #310). The seventh assessment was also completed in 2010. Although the three assessments completed in 2010 adhered to the guideline for annual assessment, these were incomplete as they did not assess the individual's skills and needs as they related to living, working, and recreating in community environments. It appeared that prior to the introduction of the Positive Assessment of Living Skills, the Abilene State School Comprehensive Functional Assessment was completed. While this tool assessed a range of skills, some of the assessments were incomplete or contained contradictory information. For example: ▪ Individual #486 was noted to be unable to complete most self-care skills independently, but no additional information was provided regarding the breakdown of skills in each area. ▪ Individual #61 was noted to have good toileting skills (i.e., uses toilet without accidents or assistance), but then a note was included that this individual did not clean thoroughly and often had soiled clothing. As noted in the baseline report, only certain sections of the PALS were used to assess an individual's skills and needs, resulting in a lack of comprehensive assessment for some individuals. For Individual #540 and Individual #398, only four of 41 sections were completed. For Individual #310, five of 41 sections were completed. While some areas may not be applicable for the individual (e.g., Adaptive Equipment Care, Mobility Skills for Those with Visual Impairments), a comprehensive assessment should be completed to ensure that all adaptive skill needs are identified.	Noncompliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each	As noted above, assessments that are completed at the Facility were frequently incomplete. This did not allow the PSTs to determine the full range of needs of the individual, and seriously hampered the development of a comprehensive plan of services.	

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	individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As noted during the baseline visit and again in Sections S1 and S2, teaching guidelines provided in the Training Documentation Reports were incomplete. Many examples are provided above with regard to Section S.1 of the SA of strategies and supports that did not effectively address individuals' needs for services and supports, and/or were not practical or functional. Without a clear understanding of how to implement effective teaching strategies, staff will be unable to bring about positive behavior change and learning. Steps have been initiated to improve this situation. The QMRP Coordinator reported that a QMRP Educator had been hired, and the Behavior Analyst had developed a draft for training staff in educating individuals with developmental disabilities. The QMRP Coordinator also provided a draft of a revised Training Documentation Report. Staff should explore the literature in both Applied Behavior Analysis and Special Education for guidance in developing staff training materials and teaching programs. All habilitation programs should, but did not, identify the setting in which training will occur. Further, it will be essential to identify steps to follow to ensure that maintenance and generalization of acquired skills is complete. Without this programming for continued use of the skill in the settings and situations in which it is needed, the individual's ability to participate in increasingly less restrictive environments is severely compromised.	Noncompliance
	(b) Include to the degree practicable training opportunities in community settings.	While many Personal Support Plans indicated that the individual would have an opportunity to participate in community activities, objectives did not specify training steps for community-based learning.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. As noted in the baseline report, consideration should be given to the completion of comprehensive assessment of all areas of adaptive behavior. Such assessment should be completed annually to ensure that Personal Support Plans address all areas of need.
2. Skill acquisition programs should be written to include the following:
    a. A behavioral objective that includes a description of the conditions under which the behavior is to occur, a description of the behavior in observable and measurable terms, and the criteria used to determine mastery;
    b. A schedule for training include the number of opportunities to be provided;
    c. The setting in which training will take place;
    d. Specific materials needed;
    e. Guidelines for teaching including the discriminative stimulus, prompting strategies, fading of prompts, task analysis where appropriate, and the implementation of shaping and chaining strategies;

f. Identification of reinforcers;
g. Schedules of reinforcement;
h. Error correction procedures;
i. Steps taken to ensure maintenance and generalization of newly acquired skills, including data collection; and
j. A description of baseline procedures should also be provided.

3. Staff should receive training on teaching individuals with developmental disabilities. The draft training program developed by the Behavior Analyst is a good first step, although expansion of the program is recommended. Materials that staff might want to review are presented in Cooper, Heron, and Heward (2007), as well as that presented by Snell and Brown (2011). Ongoing support and training should be provided to staff on-site.
4. Data collected on all skill acquisition programs should be presented graphically, and reviewed at a minimum of once quarterly. This will allow for ongoing monitoring with program revisions completed in a timely manner. If training is not accomplished due to individual refusal to participate, psychology staff should be involved to help design programs to improve participation be it through change in presentation, choice in activity, or something similar. Data also should be collected to evaluate the success or failure of maintenance and generalization of newly acquired skills.
5. Staff are encouraged to examine and expand the variety of activities available in all environments to ensure greater engagement among the individuals served. Particular attention should be paid to providing activities that are functional, age-appropriate, and of interest to the individual.
6. A system for monitoring and increasing overall engagement rates is strongly advised. This will afford administrative, and support staff the ability to identify areas of need and will allow for constructive feedback to the staff who provide the day-to-day programming. Staff are encouraged to expand the variety of home, leisure, and vocational activities available to the individuals served.
7. Greater community involvement, including enhanced training in the community, should be a prioritized goal of the Facility. Individuals should have increased opportunity to engage in both leisure and vocational activities in the community, and should be provided the necessary supports to learn and be successful in the same.

References:

Cooper, J.O., Heron, T.E., & Heward, W.L. (2007). *Applied Behavior Analysis (second edition.)* Upper Saddle River, NJ: Pearson Prentice Hall.

Snell, M.E., & Brown, F. (2011). *Instruction of students with severe disabilities (seventh edition).* Upper Saddle River, NJ: Merrill Prentice Hall.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individuals Assessed for Placement since 1/1/10; o List of Individuals Referred for Placement since 1/1/10; o List of Individuals who Have Requested Placement since 1/1/10; o List of Individuals who Have Had a Community Living Discharge Plan (CLDP) developed since 1/1/10; o List of Individuals who Have Been Transferred to a Community Setting since 1/1/10; o List of Individuals Discharged Pursuant to an Alternate Discharge, since 1/1/10; o List of Individuals who Have Returned from a Community Placement since 1/1/10; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09; o DADS Policy Number 018.1, entitled "Most Integrated Setting Practices", dated 3/31/10; o Living Options Discussion Record (blank), revised 12/14/09; o ABSSLC Verification of Essential Supports form (blank), undated; o Post-Move Monitor's reports to the State Office for five PSP meeting, various dates April through August 2010; o Blank form letter regarding Medicaid coverage given to providers as part of transition process; o Community Placement Report, undated; o Monitoring Tool used to monitor the community living/transition, and post-move monitoring process, undated; o Completed monitoring tools regarding the community living/transition, and post-move monitoring processes for June and July 2010; o Summary data for monitoring completed entitled "Planning for Movement, Transition, and Discharge (Section T)" for June 2010 and July 2010; o ABSSLC Tour Activity from 1/1/10 through 7/6/10; o Save the Date letter for Provider Fair scheduled on 9/23/10, dated 8/23/10; o Draft Community Living Discharge Plan for Individual #58; o PSPs, assessments considered during the PSP process, Personal Focus Worksheet, Community Living Options Information Process (CLOIP) worksheet or permanency plan, sign-in sheets for PSP, PSP addenda, if any, quarterly/monthly review documentation and associated skill acquisition programs for the following individuals: Individual #411, Individual #243, Individual #447, Individual #357, Individual #341, and Individual #102; o PSPs with related assessments for the following: Individual #486, Individual #49, Individual #538, and Individual #111; o CLDP, any associated assessments, most recent PSP, post-move monitoring checklists, and any notes regarding follow-up on issues identified with their community placements for the following individuals: Individual #318, and Individual #51;

	○ CLDP, any associated assessments, most recent PSP, MRA Verification of Essential Supports, and IPP/Cost Plan, as available, for the following individuals: Individual #171, Individual #41, Individual #93, Individual #548, Individual #244, Individual #416, Individual #51, and Individual #341; and ○ Post-Move Monitoring Checklists for the following individuals: Individual #221, Individual #352, Individual #41, Individual #66, Individual #171; Individual #244, Individual #51, Individual #548, Individual #93, and Individual #416 ▪ **Interviews with**: ○ Pat Smith, Admissions/Placement Coordinator (APC); ○ Laura Wilford, Post-Move Monitor; ○ Juan Herrera, QMRP Coordinator; ○ Five QMRPs involved in the PSP Pilot Project, including Kristin Wyrick, Kelli Garret, Yvonne Chambers, Haley Savage, and Candice Wilkins ▪ **Observations of**: ○ Community Living Discharge Planning Meeting for Individual #58; ○ PSP Annual Meeting for Individual #337; ○ Post-Move Monitoring Visit for Individual #548; and ○ Post-Move Monitoring Visit for Individual #171
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for ABSSLC did not include this component, the POI correctly identified that overall ABSSLC was currently not in substantial compliance with the requirements of Section T of the SA. The POI indicated compliance with some of the indicators within this section, including: ▪ The indicators related to CLDPs being developed in timely manner. However, as is illustrated below, many CLDPs were being developed within a couple of weeks of an individual's discharge, making adequate planning and implementation difficult. In addition, protections, supports and services were not yet being defined adequately in CLDPs. ▪ The indicator related to the MRA verifying essential supports were in place at the time of the transition. As is illustrated below, a verification process was in place, but it was substantially flawed. ▪ The section related to post-moved monitoring visits. However, as is discussed below, in addition to some issues related to timeliness, the content of the post-move monitoring checklists still was not adequate. The Facility's self-assessment with regard to providing the Monitor and DOJ with a community placement report was consistent with the Monitoring Team's finding. Interestingly, though, this component was not in compliance until the Monitor was on-site. The Facility's POI had been submitted a couple of weeks earlier with the finding of substantial compliance. As also is discussed below, a number of concerns were noted with regard to the monitoring process being used by the QE Department with regard to Section T. These concerns raised questions with regard to both

	the reliability and validity of the data.
	Summary of Monitor's Assessment: With regard to the availability for funding for community transition of individuals from ABSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. As was reported in the baseline report, and is further discussed in the section of this report that addresses Section F of the SA as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals need to ensure safety and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important both to help identify an appropriate community provider and/or configuration of supports and services, as well as to ensure that adequate post-move monitoring occurs. Since the baseline review, when no obstacles to individuals' movement to the most integrated setting were identified in PSPs, improvements had occurred in that the newer plans included obstacles and plans to overcome them. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. However, there continued to be concerns regarding the content of the checklists in relation to documenting the process that was used to confirm that essential and non-essential supports were adequately in place.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	As reported in the baseline report, on 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This policy was updated on 3/31/10, with minor revisions. This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from ABSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day timeframe. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. The professional teams supporting individuals at ABSSLC should make independent recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.	Noncompliance

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T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	As reported in the baseline report, in response to the document request for all Facility policies related to this section of the SA, the Facility submitted a copy of the State's policy. This policy is discussed above with regard to Section T.1.a of the SA.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The two major requirements of this section of the SA are discussed separately below: <u>Identification in PSP of needed protections, services and supports</u>: As was reported in the baseline report, and is further discussed in the section of this report that addresses Section F of the SA as well as throughout other sections of the report, PSPs generally did not identify the comprehensive array of protections, services, and supports that individuals need to ensure safety and the provision of adequate habilitation. In all of the PSPs reviewed, concerns were noted with regard to their completeness. Some of these issues related to thorough and adequate assessments not being completed (e.g., nursing, physical and nutritional management, and communication); services and supports not being adequately integrated with one another (e.g., psychology and psychiatry, psychology and dental/medical, and occupational and physical therapy); protections, services, and supports not being adequately defined, such as a lack of specificity about the supports that direct support professionals need to provide to protect and support individuals with regard to behavioral, therapeutic, or healthcare issues; and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychology and habilitation, physical and nutritional supports, and communication). It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them as well as potential providers to have a clear idea about what protections, supports and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition.	Noncompliance

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		Identification of obstacles and strategies to overcome them: Since the baseline review, when no obstacles to individuals' movement to the most integrated setting were identified in PSPs, improvements had occurred in that the newer plans included obstacles and plans to overcome them. However, the following issues were noted: 1) the obstacles often were listed as need areas for the individual, such as behavioral issues, medical concerns, etc., as opposed to identifying services or supports that either were unavailable or did not exist in the community; 2) the plans to overcome the obstacles often were not measurable, did not identify person(s) responsible or timeframes for completion; and 3) the strategies often involved services to be provided to the individuals at the Facility, but did not include identifying support configurations in the community that would address individuals' needs. For example: ▪ Individual #102's 5/25/10 PSP included a Living Options Discussion Record/Permanency Plan that listed the obstacles as age, conduct disorder, and challenging behaviors. The strategies for overcoming these obstacles were not included as action plans, and did not include measurable action steps, person(s) responsible, or timeframes for completion. With regard to age, the team had noted that: "Many facilities do not allow minors to live in their facility. Continue to find appropriate living options that will accept people under the age of 18." It appeared that the first sentence of the plan was really the description of the obstacle. It was not clear, though, who was going to assist in finding appropriate living options, what specific steps would be taken to do this, and within what timeframes. To address the obstacle identified as Individual #102's behavior, the team referenced implementation of his PBSP, taking medications as directed, and documenting all behavioral occurrences. It appeared that the actual obstacle to transition to a community setting was not his behavior, but the lack of resources in the community to address his behavioral needs. If the team had identified this as the barrier, then in addition to steps the Facility was taking to provide treatment to address his behavioral issues, other action steps to identify appropriate community supports also should have been included. ▪ Individual # 357's team identified medical issues, the limitation of residential providers in the 50-mile radius identified by she and her mother, and the lack of openings at homes in this area. No action plans were included in the PSP to address the identified obstacles, although it was noted that her medical issues were being addressed surgically. ▪ The PSP for Individual #243 identified medical/dental and behavioral needs as obstacles. After it appeared his team had discussions with the dentist, it was determined that it was in his best interest to complete extensive dental work that he currently was having completed prior to considering transition. Although the plan was not stated in measurable terms, it did appear that the team had talked through a plan for having the dental work completed. However, with regard to his behavioral needs, the team emphasized the need for his PBSP	

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		to be implemented and for him to complete social skills training before moving to the community. No strategies were included to identify an appropriate configuration of services and supports in a community setting that could address his behavioral and social skill needs. During the August 2010 review, the QMRP Coordinator reported that ABSSLC had been piloting a new PSP format since June 2010. Five QMRPs were involved in the pilot project. In a meeting with the QMRP Coordinator and these five QMRPs, they indicated that the new format of the meeting helped teams to discuss the living options component in a more expansive manner, and this discussion started with what was most important to the individual. By shifting the focus to what was most important to the individual, reportedly the teams were able to begin to evaluate the individual's current living situation in the context of his/her preferences, strengths, as well as needs. At times, this resulted in recommendations for changes to the configurations of supports and services being provided at ABSSLC, community integration opportunities, as well as possibilities for supporting the individual to move to a community setting. QMRPs involved in the project reported that this approach also appeared to be one that families and guardians received positively. The Monitoring Team reviewed a sample of PSPs that had been developed using the revised methodology and PSP template. The same issues noted above with regard to the identification and planning around obstacles to community transition that were found in the older format PSP were noted in the newer formatted plans. For example: ▪ Individual #49's plan listed a number of barriers, but they generally were worded in terms of his needs as opposed to supports or services that were not available in the community. They included for example, that he requires 24-hour nursing [the specific nursing supports or type of nursing (e.g., RN versus LVN) were not identified], that he needed specialized transportation, that he was unable to grasp an object for more than 25 seconds, and weather such as extreme temperatures were a concern. Some of the obstacles were listed in terms that described more the services that were needed but not available, such as a lack of extensive therapies (OT, PT, etc.) in a centralized location. This was an obstacle that was worded in such a way as to allow action to be taken to either identify or develop appropriate supports. It also was mentioned that his guardian preferred him to be served at ABSSLC, and that the guardian's specific concerns about transition to a community setting appeared to relate to the lack of specialized medical and therapy services in other settings. This description of the guardian's concerns was helpful information. However, the only action plan related to the discussion about obstacles appeared to be that Individual #49 would participate in community exploration activities.	

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		▪ The 7/30/10 PSP for Individual #486 identified his behavioral issues as an obstacle. It also stated: "Lack of ability to maintain increased staffing levels of supervision," and "Restraint of SIB." It was not clear if these were supports that the team felt were not available in the community. There was mention of implementation of his PBSP, but it did not appear that the team had developed any specific action plans to address the obstacles it identified. As reported in the baseline review, the Post-Move Monitor had begun to attend a sample of PSP meetings to provide teams with feedback regarding the community living options discussion. The Monitoring team reviewed a sample of six of the completed forms, entitled "Living Options Discussion Meeting Monitoring Checklist." In some cases, the Post-Move Monitor had noted good team discussions regarding individuals' preferences. It was not clear from the forms that teams were defining specific obstacles, or that plans were consistently generated to overcome such obstacles. For example: ▪ Individual #164's team appeared to have identified his inability to tolerate participation in a six-hour day program as a problem in the Home and Community-based Services (HCS) system. However, the Post-Move Monitor had not noted that any action plans were developed to address this potential obstacle. ▪ Individual #357's team deferred a referral due to recent medical issues she had experienced. It was not clear from the monitoring checklist, if her team had considered developing action plans to address this barrier, such as identifying a provider who could meet her current medical needs. It also was not clear if the team had identified and developed plans to address other potential obstacles so that when her medical issues were resolved the process of identifying an appropriate configuration of supports would be further advanced. As noted above, based on the Monitoring Team's review of Individual #357's PSP, other obstacles were identified, but no action plans to address them were developed. It was unclear how the State Office was using the information gathered as a result of this process. The Facility was not generating any summary data of the information, and the State Office had not provided the Facility with any summary data, or any feedback on the forms. When asked, the Post-Move Monitor reported that she had not been asked to provide any specific feedback to the teams, although, at times, she had talked with the QMRPs about some of her observations.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families	ABSSLC had continued to engage in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. This has taken a number of forms, including: ▪ On 9/22/09, a provider fair was held. It appeared from the sign-in sheets that it was well attended by providers, individuals, and Facility staff. Another provider	Noncompliance

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	or guardians to enable them to make informed choices.	fair was scheduled for September 23, 2010. All of the families of individuals served at ABSSLC were being sent information. Fliers about the event also were being posted in homes on campus. ▪ Visits to community group homes and day programs were occurring approximately one to two times per month. Each home on campus was assigned a date for the tours, and they offered this opportunity to individuals living in the home. Based on review of individuals' PSPs, at times, teams included this as an action step to provide individuals with greater exposure to options available in the community. ABSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This was occurring regularly as part of the individual planning process. ▪ In addition, Mental Retardation Authorities (MRAs) also had met with PST members in meetings designed specifically to provide information about services and supports that are available in the community. For example, this occurred in conjunction with the provider fair on 9/22/09. Similar sessions were being planned for this fall, and it was reported that families were going to be invited to attend. ▪ As noted in the baseline report, ABSSLC was fortunate to have a number of staff, including the Post-Move Monitor who have had experience working in the community system. This allowed the Post-Move Monitor, for example, to assist in answering questions about the community that individuals, families/LARs, or other staff may have. The most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. The Living Options Discussion Records reviewed did some of this, but they tended to make general statements about review of information from the MRA. This process will be facilitated as teams begin to better define obstacles to transition, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories, or individuals from the Facility could visit them in their new homes and day programs. At times, it might be helpful to match individuals and/or	

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		guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This allows someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The SA anticipated that the Facility would require 18 months to complete this activity. However, to assess the Facility's progress, the Monitoring Team requested as part of its document request a list of individuals who had been assessed for placement since July 1, 2009, pursuant to the new or revised policies, procedures, and practices related to transition and discharge practices. The list provided appeared to be a list of all individuals who had had an annual staffing meeting since 7/1/09. As is discussed above with regard to Section T.1.a of the SA, the individuals' PSPs that were reviewed did not document an independent assessment by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. The Facility's POI documented that compliance had not been attained for this requirement, and indicated that the ABSSLC policy would be revised.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Since the baseline review, staff reported that efforts were being made to begin the Community Living Discharge Plan process sooner. During the week of the on-site review, a meeting was held that illustrated this process: ▪ Individual #58's team met to discuss and develop the CLDP prior to his going on community visits potentially to select a provider. This provided the team an opportunity to discuss the supports that he and the providers he was visiting needed to make the visits successful. It also provided Individual #58 and his team the opportunity to begin to plan, and think about the supports that would be required were he to transition to the community. The meeting was facilitated by the Admissions/Placement Coordinator who elicited from Individual #58 and his team a number of essential supports that needed to be in place both when he went on the visits, as well as when he transitioned. For example, a plan was developed for the staff accompanying him on the initial visits to provide training on some key elements of his PSP to the provider staff. It was anticipated that the team would meet again as the community visits were completed to obtain Individual # 58's feedback on the visits, as well as to develop further the CLDP. Community Living Discharge Plans were reviewed for eight individuals. This sample was drawn from the list of 16 individuals whom the Facility identified as having had a CLDP	Noncompliance

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		developed since January 1, 2010. With regard to the timeliness of the development of the plans, none of the eight plans (0%) were developed in a timely manner. It appeared that all were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. For example: ▪ Individual #244 transitioned to the community on 7/2/10, but his CLDP was developed only a few weeks prior on 6/14/10. ▪ Individual #548's CLDP was developed on 6/10/10 for a transition that occurred on 6/24/10. ▪ Individual #171 transitioned to the community on 5/13/10, but her CLDP was developed only about a week prior on 5/5/10.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. Two of the eight (25%) (Individual #244 and Individual #51) identified some of the steps that the Facility would take to ensure a smooth and safe transition. However, these often were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. Some examples about concerns noted with regard to the specificity of the actions steps the Facility would take or the lack of identified action steps included: ▪ The Community Living Discharge Plan for Individual #244 included action steps for staff from ABSSLC to train provider staff on medical information, psychological information and the PBSP, and program information related to daily routines, training skills, and his likes and dislikes. However, none of the action steps provided details regarding who would be trained, how the training would occur (e.g., staff from the provider agency spending time at ABSSLC, or in-service training on-site at the new home and day program), or what level of training was expected (e.g., verbal review of the plans, competency-based training, etc.). Many other actions of Facility staff were not mentioned, or were not assigned responsibility. For example, a parenthetical mention was made of the fact that a pair of supportive tennis shoes would be sent with him, but no responsibility was assigned. It can be assumed that many activities needed to occur to ensure that he physically moved from ABSSLC to his new home. However, none of these were mentioned. For example, there was no delineation of responsibility for ensuring a supply of medication went with him, who would transport him, or if ABSSLC staff would go with him to his new home on the first day. ▪ The CLDP for Individual #171 did not adequately identify the steps Facility staff would take. Most of the action steps included the new provider staff's responsibilities. It was unclear what role Facility staff would taken in training and/or sharing information with the new provider, or assisting in	Noncompliance

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		the actual transition process. ▪ In the narrative section of Individual #93's CLDP, it was reported that ABSSLC had provided in-service training to provider staff on her "needs, likes, dislikes, her programmic (sic), medical, behavioral, and communication issues… This was completed at the CLDP meeting." Although there was no indication of how long the meeting was, it was unclear how full in-service training could be provided on this number of topics and plans in any meaningful way during the course of a meeting in which a comprehensive plan was supposed to be developed. In addition, no action steps were actually included in the transition plan portion of the document identifying actions the Facility would take with related timeframes for completion. Again, in the narrative portion, the ABSSLC nurse was reportedly going to conduct follow-up on some medical issues or questions. This was not incorporated into the plan.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	As noted above with regard to Section T.1.c.1, CLDPs did not identify the full array of actions in which Facility staff needed to engage to ensure safe and smooth transitions, nor did they consistently identify the specific staff responsible or the timeframes in which such actions needed to occur. Three of the eight CLDPs (38%) identified specific staff by name, including those for Individual #244, Individual #51, and Individual #548.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Based on review of eight CLDPs, six of the eight (75%) included documentation that the plans had been reviewed with the individual and/or the LAR. For the plans for Individual #416 and Individual #41, it did not appear that they were in attendance at the meeting, and it was not clear why.	Noncompliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	It appeared that a process had been put in place to improve compliance with this requirement. Brief updates often were included to supplement full assessments or evaluations that had been completed as part of an earlier PSP process. These updates indicated that reviews had been completed of the previous documents, and provided new information, as applicable. This was helpful in determining what had changed with the individual since the formal assessments had been completed. For four of the eight CLDPs reviewed (50%), it appeared that this new process had resulted in updated assessment information being included from all disciplines. For Individual #416, Individual #244, Individual #41, and Individual #318, timely updated assessment information was not found for all assessments.	Noncompliance

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		A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	As reported in the baseline report, the CLDPs reviewed included essential and non-essential supports. Since the baseline review, improvements had been made with regard to the definition of essential and non-essential supports, but ABSSLC was still at the stage of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Although some of the plans included individuals' preferences (e.g., Individual #548's preference for a swing both in his room, and on the deck outside), not all of the plans consistently identified preferences of the individuals that might affect the success of the transition (e.g., Individual # 51's preference for male staff). This made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. In none of the eight plans reviewed (0%), was a comprehensive set of essential and non-essential supports identified in measurable terms. The following are examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #244's CLDP listed many essential supports, as well as non-essential supports. However, some key elements of the services and supports were not captured in measurable terms. For example, he had a behavior support plans, the implementation of which appeared to be important to ensure his success. There was an essential support listed for staff to be trained on the plan. As noted previously, this was not measurable. There was no essential support listed to ensure that staff at his new home and day program implemented Individual #244's PBSP. "Psychological Services" was listed as a non-essential support. A due date of a month after he moved was assigned to this support. No one was identified as responsible, and no details were provided with regard to what these psychological services would entail. For example, no qualifications regarding the psychological services staff were provided, no frequency of involvement by the psychological staff was noted, and no description of	Noncompliance

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		what such services would entail was provided. Individual #244 was placed at ABSSLC due to problems related to his behavior, making it essential that proper supports be in place to ensure his success in the community. ▪ The CLDP for Individual #51, who transitioned to the community in mid-June 2010, included a number of important essential and non-essential supports, and efforts had been made to identify specific persons responsible. However, some of the supports that appeared as essential to be in place immediately to ensure his successful transition were identified as non-essential supports. Specifically, "Services in place for psychologist and psychiatrist" was listed as a nonessential support with a due date 60 days after his transition. Although the plan required the "BSP [to be] in place to address target behavior of aggression," the due date for this also was listed as two months after his move. At the time of the Monitoring Team's review, Individual #51's community placement was in jeopardy due to his behavioral issues. Based on interview with Facility staff, Individual #51 moved to the one provider that was available in the area in which his family lived. Within the first seven days of his transition, the provider was having difficulties addressing his behavioral concerns. The Facility team conducted another in-service training for staff on his BSP. At the time of the Monitoring Team's review, a primary care physician in the community had seen Individual #51 and increased his psychotropic medications, but the provider had not been able to secure an appointment with a community psychiatrist until over 60 days after his transition. Reportedly, this was due to the psychiatrist's office requiring Individual #51 to have a Medicaid card, which often was not available for weeks or months after individuals transitioned to the community as a result of the need for institutional Medicaid to be transitioned to community Medicaid. In addition, it did not appear that the community provider had been able to provide adequate psychological/behavioral services. The behavior analyst only was available to the home one time a month, and had not seen him in July, but was planning to see him in August. Although this technically met the requirements of Individual #51's transition plan, it clearly did not meet his needs. It should be noted that the psychologist from ABSSLC had visited Individual #51 in his new home twice to in-service direct support professionals and the home supervisor, and the provider staff had been to ABSSLC once. However, Individual #51 required ongoing oversight and supports from behavioral staff at his new home from the first day of his arrival. This had not been identified adequately in his CLDP. Staff also reported that Individual #51 historically had responded better to male staff as opposed to female staff. He also reportedly was aware if staff were afraid of him. Neither of these issues was noted or addressed in his CLDP. For	

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		example, there was no requirement that at least one male staff be available on each shift. There were no plans in the CLDP for community provider staff to establish a relationship with Individual #51 at ABSSLC prior to his transition to the community. The State and Facility should conduct a critical analysis of Individual #51's transition planning and implementation processes. Individuals' transition plans, particularly the definition of essential supports, should not be based on what is available, but rather what the individual needs. It appears that for this individual, it was essential that on the day of his transition that psychological/behavioral and psychiatric services were in place, and that these services meet certain criteria (i.e., clinicians with experience in developing and overseeing treatment and supports for an individual with autism and significant behavioral issues). If the transition from institutional Medicaid to community Medicaid is an issue that prevents such essential services from being identified as essential supports and being in place on the day of the transition, then this needs to be identified as an obstacle, and addressed, if necessary, on the State level. Based on interview, some community medical providers were willing to accept just the Medicaid number with assurances in the form of a letter from the Facility that the number was a working number, but others refused to provide treatment without a Medicaid card. ▪ Individual #548 had a number of physical and nutritional support needs. The only essential or non-essential support listed in this regard was that ABSSLC would provide in-service training on "Wheelchair and all adaptive equipment… Dining Plan." The specific staff person(s) who would provide this training were not identified. Based on a 5/24/10 OT/PT Annual Evaluation, it appeared that oversight and monitoring was being or should have been provided by ABSSLC therapists of his PNMP that included the use of adaptive equipment, such as his wheelchair and adaptive mealtime equipment; a positioning and transfer program; and a mealtime plan. For example, he had been participating in PNMP clinics to ensure the adequacy, fit, and good condition of his wheelchair, and his mealtime/dining plan was being reviewed at least annually, and updated by therapy staff, as needed. His CLDP did not include plans to ensure that he continued to have access to appropriate therapy services once he transitioned to the community. For example, there was no measurable outcome to ensure that he was connected with therapy staff in the community who had the expertise to address his physical and nutritional support needs, and that such therapists would be available to conduct similar assessments and oversight of his plans as were available and apparently necessary while he was at ABSSLC. There was no	

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		specific mention in his CLDP of his positioning plan. Moreover, his 5/24/10 OT/PT evaluation indicated that: "[Individual #548] participated in a PNMP clinic with PT, OT, nursing and orthotics on 4.23.10. His current system was clean and in good repair, but is an older system. The team recommended ordering a Bentley frame with contoured back and planar seat from National Seating and Mobility. Due to [Individual #548] moving to the community, this recommendation can not be completed due to time constraints." His CLDP provided no plan for follow-through on this recommendation to ensure that his needs were met with regard to a new wheelchair. Generally, an individual's needs do not change on the day he/she transitions to the community. Needs reflected in the individual's PSPs, and related plans and assessments should be reflected in the CLDPs, and CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community. Vocational needs of individuals, such as Individual #548, generally continued to be defined in vague terms. For example, Individual #548's CLDP included a non-essential support for him to be provided "opportunity to participate in pre-vocational training or appropriate day habilitation." Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. With regard to monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, none of the eight plans (0%) showed evidence of confirmation that each of the essential supports was in place at the time of the transition. For individuals transitioning from ABSSLC this monitoring took two forms. One the MRA completed, and the other the Post-Move Monitor completed. The MRA process appeared from the records reviewed to be a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared to be based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site	

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		administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions did not represent adequate proof that the essential services required by the CLDPs were in place. None of these forms for the sample reviewed provided any additional documentation to show that the MRA representatives had actually confirmed that the individualized essential supports were in place. Based on interview, the Post-Move Monitor and Admissions Placement Coordinator recognized that these were not adequate assessments. In an attempt to correct this deficiency, the Facility had developed a form entitled "Verification of Essential Supports and Services." However, this form was simply a sign-off by a provider representative and Facility representative of the statement: "The above essential supports and services are available prior to or at the time of the transition to the community." On the forms reviewed, no essential supports were listed, and there was no description of the activities undertaken to confirm that the essential supports were in place or available.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	ABSSLC had begun utilizing the Monitoring Teams' review tools to review PSPs, CLDPs, and most-move monitoring documentation related to the community living and transition processes. A number of issues were identified with regard to the Facility's implementation of these tools, particularly with the tools that had been completed with regard to the PSPs and CLDPs. A total of 29 completed monitoring tools were reviewed, including 22 for PSPs and CLDPs, and seven for the post-move monitoring process. These concerns included: ▪ For many individuals whose PSPs had been reviewed, the column for "not applicable" had been checked all the way down the tool. There were a number of indicators on the tool that would be completed for everyone, including, for example, indicators related to the assessments completed and determinations made by professionals regarding appropriateness of community placement; comprehensiveness of individuals' PSPs with regard to protections, services, and supports; the identification of obstacles to community transition; and the development of action plans to overcome them that were measurable. ▪ There were concerns regarding the reliability of the data. There appeared to be inconsistencies in ratings even when the same auditor had completed the tool. For example, "not applicable" was checked for the identification of obstacles and plans to overcome them for Individual #207, with a note stating: "No major obstacles indentified in the Living Options discussion record." The same note was included in the audit tool for Individual #510, but "no" was checked for these same indicators. ▪ There was concern regarding the validity of the data collected. As noted throughout this report, the Monitoring Team identified numerous issues	Noncompliance

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		related to the comprehensiveness of individuals' PSPs. However, many of the audit forms indicated that PSPs identified all of the protections, supports, and services the individuals needed. This also was true with regard to the appropriate identification of obstacles to community transition, which as discussed above was consistently inadequate. However, Facility reviewers found them to be adequate for a number of individuals. ▪ Good portions of many of the audit tools had been left blank. This appeared to be due to the fact that the Monitoring Teams have included all information on one tool, as opposed to splitting them up into multiple tools used, for example, for individuals who are not yet in the transition process, those who are, and for more Facility or systemic issues, such as the compilation of data related to obstacles, the QE process, etc. This is an example of where reconstructing the tools so that they are most appropriate for use by the Facility would be beneficial. Although the Facility provided summary data based on these audits, the concerns noted above with regard to reliability and validity made the data largely unusable. The Facility indicated that no plans of correction had yet been initiated for this section of the SA. As is discussed above with regard to Section E of the SA, the monitoring tools should be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate. In addition, staff conducting the audits should complete competency-based training, and a system for inter-rater reliability needs to be established.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive	Based on interview, the Facility had not yet been entering data with regard to obstacles into a database to allow it to be aggregated. As noted above, the obstacles that teams were identifying were not yet adequately defined.	Noncompliance

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	assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services	While on-site, the Facility provided the Monitoring Team with a list of individuals who had been referred for placement in the community, including the date of the referral; a date of the move, if the individual had transitioned to the community; and an indication if the referral had been rescinded. The State also provided this list to DOJ. The list provided showed that since 1/1/10, 16 individuals had moved to the community, and an additional eight individuals had been referred for transition. Three of the eight referrals had been rescinded, and five were in the transition process.	Substantial Compliance

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	provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was provided for 10 individuals. For these individuals, 22 reviews should have been completed. Of the 22 required visits, 19 (86%) had been documented as having been completed on time; and the remaining three (14%) were late or not provided (i.e., for Individual #221, and Individual #51). In addition, based on the documentation, it could not be determined if visits had been made to both the residential and day sites of the individuals. Often, the notes indicated that either one setting or the other was visited, but not both. In order to adequately ensure that all essential and non-essential supports are in place, visits should be conducted in whatever settings protections, supports and services are being provided. <u>Content of Checklists</u>: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists completed had been addressed. Efforts clearly were being made to add additional information regarding the interviews conducted, the documents reviewed, and the observations made. However, this information was not consistently complete, which raised questions about the adequacy of the reviews. The following provides examples of concerns noted with regard to individuals' post-move monitoring checklists: ▪ As noted above, at the time of the on-site review, Individual #51's community placement was in jeopardy due to his provider's inability to address his support needs, particularly with regard to his behavioral issues. According to verbal report, issues had been identified within the first week. However, the Post-Move Monitoring Checklist, dated 6/22/10, did not clearly illustrate these issues. For example: o His non-essential supports related to behavioral supports indicated that he was to have "BSP in place to address target behavior or aggression. Services in place for psychologist and psychiatrist." The note beside this	Noncompliance

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		support on the monitoring form stated that the provider "has both a psychiatrist… and Psychologist…that are contracted." This indicator was marked as a "yes" as being present. This gave the impression that his BSP was being implemented correctly, and that he was receiving the psychological and psychiatric services needed. However, the narrative portion of the report indicated that he had engaged in a number of aggressive acts toward staff. Although the notes referenced that logs were reviewed, and staff interviewed, it what not clear what review was done to ensure that the BSP was being implemented as written. Also, as noted above, the provider technically, according to the CLDP, had 60 days to set up an appointment with the psychologist, and psychiatrist. However, the note beside this indicator gave the impression that both were under contract, and were providing supports. As is discussed above with regard to Section T.1.e of the SA, neither were involved, which likely contributed to staff not having the proper tools to address his behavioral issues. ▪ A checklist that was completed for Individual #66 on 7/8/10, indicated that his numerous pieces of adaptive equipment were present. No indication was provided of how this was confirmed. Although there were notes regarding the in-servicing of staff on his many programs, there was no evidence provided in the notes that there was confirmation that his many programs were being implemented adequately. For example, he had a positioning program. Although it was noted in the narrative that he was in bed being at the time of the visit per the plan, and there were pictures on the wall, there was no indication of whether documentation was reviewed to determine if the positioning program was being implemented as written. The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. Generally, it appeared that issues were being identified, and followed through to conclusion. Notes identifying actions taken were documented on the forms.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor and the APC on two post-move monitoring visits for Individual #171, and Individual #548. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. Both of these reviews consisted of visits to the individuals' day programs and homes. In addition, ABSSLC staff were very helpful in providing ideas to address issues raised, and/or offering to put community provider staff in touch with other ABSSLC staff who might be able to assist. As noted above, it will be important for these activities to be thoroughly	Substantial Compliance

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	the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	documented on the monitoring forms. Based on the reviews that were conducted for Individual #171 and Individual #548 in comparison with their CLDPs, it appeared that the Post-Move Monitor reviewed relevant documentation, and conducted appropriate observations and interviews. It should be noted, however, that the concerns identified above with regard to the continuing need for the depth and quality of CLDPs to be improved will affect the level of monitoring that will be required. As CLDPs are improved, and there are additional measurable services, supports, and protections included in the plans, the expectations for the Post-Move Monitor will increase. At this juncture, the plans, including those for Individual #171 and Individual #548, included few, if any requirements, regarding the implementation of plans, for example, Behavior Support Plans, Physical and Nutritional Support Plans, etc. As is noted above, it is essential that modifications be made to the CLDPs to ensure they include comprehensive and measurable definitions of the protections, services and supports provided. This will require the Post-Move Monitor to conduct many more observations of, for example, meal times, and will require much more extensive review of data, such as behavioral data, data related to PNMPs, interviews with direct support professionals to ensure their understanding of such supports, etc. Continuing findings of substantial compliance for this requirement of the SA will be dependent on post-move monitoring activities keeping pace with the evolution of the community living discharge planning process.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing	At the time of this review, no alternative discharges had occurred. However, as reported	Substantial

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	provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	in the baseline review report, based on a review of the discharge summary completed for Individual #380, it appeared to meet the CMS requirements as it included a summary of the individual's developmental, behavioral, social, health, and nutritional status.	Compliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The professional teams supporting individuals at ABSSLC should independently make recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
2. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
3. Efforts should continue to be made to begin the process of developing the CLDP much sooner to ensure that a comprehensive plan is developed,

and that there is time to implement an adequate transition process.

4. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility staff in the transition and discharge process needs to be defined better;
    b. As nuances are learned with regard to the community system, individuals' CLDPs should include essential supports to address the need for such specific protections, as appropriate, such as the need for locked cabinets for medications;
    c. Individuals' transition plans, particularly the definition of essential supports, should not be based on what is available, but rather what the individual needs. If, for example, the transition from institutional Medicaid to community Medicaid is an issue that prevents essential services from being identified as essential supports and being in place on the day of the transition, then this needs to be identified as an obstacle, and addressed, if necessary, on the State level. Given that it was reported that some community medical providers were willing to accept just the Medicaid number with assurances in the form of a letter from the Facility, but others refused to provide treatment without a Medicaid card, this issue might require resolution at a higher level, such as with assurances from the State's Medicaid Office.
    d. Given that generally, an individual's needs do not change on the day he/she transitions to the community, needs reflected in the individual's PSPs, and related plans and assessments should be reflected in the CLDPs;
    e. CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community; and
    f. Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc.
5. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) may be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes.
6. Likewise when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the State.
7. Teams should be provided with training on the development of action plans/strategies to overcome identified barriers. Such training should be competency-based.
8. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would facilitate the transition of this information to community medical care providers.
9. The State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., are transferred to a mental health hospital after transitioning to the community), or whose community transitions are in jeopardy.
10. If the MRAs are going to continue to be responsible for ensuring that essential supports are in place before the individual departs from the Facility, then the process for confirming this needs to be substantially improved. As required by the Settlement Agreement, the State needs to

ensure that supports considered to be essential to the individual's health and safety are verified as being present. This will require more than conversations with staff, but will entail onsite monitoring, review of documentation, observations, as well as interview. Documentation should include verification of each and every essential support identified in the CLDP, as well as the methodology used to verify their existence.

11. As is discussed above with regard to Section E of the SA, the monitoring tools should be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate. In addition, staff conducting the audits should complete competency-based training, and a system for inter-rater reliability needs to be established.
12. With regard to post-move monitoring, clear expectations should be established with regard to the process that needs to be used for monitoring, and the documentation that needs to be maintained.
13. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place, and/or steps being taken by the provider agency to ensure that such supports and services are provided.
14. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director; o ABSSLC Rights Assessment, revised June 2007; o ABSSLC Guardianship Priority Tools for Priority I and Priority II, with instructions, undated; o Blank Consent/Authorization for Rights Restrictions, dated 9/21/06; o Client Assignment and Registration System (CARE) blank form, revised 1/10; o ABSSLC Comprehensive Functional Assessment, dated 1/30/08; o Minutes from Guardianship Assistance Program, dated 7/28/10; o List as of 3/11/10 of current guardians of individuals at ABSSLC interested in becoming guardians for other individuals; and o List of Individuals with CARE designation regarding need for an advocate, undated ▪ **Interviews with**: o Shae Butts, Human Rights Officer; and o Jill Antilley, Assistant Independent Ombudsman
	Facility Self-Assessment: The Facility self-assessment showed that it continued to be in noncompliance with the requirements of Section U of the SA. This was consistent with the findings of the Monitoring Team.
	Summary of Monitor's Assessment: At the time of the review, DADS Central Office was still in the process of finalizing a policy on guardianship and consent. The Monitoring Panel had been asked to review and comment on the policy. The draft policy provided significant guidance to the Facilities, as well as practical tools to assist in the assessment processes related to guardianship. Once implemented, the policy should help the Facilities to move forward with regard to the implementation of these SA requirements. As reported previously, ABSSLC had taken some steps to identify potential guardians for individuals who needed them. Specifically, staff had approached guardians of individuals currently living at ABSSLC to

	determine their interest in becoming guardians for others. Since the last review, a list of six people had been identified. The Guardianship Committee had discussed the process of matching individuals who needed guardians with the people interested in becoming guardians. Appropriately, the Committee agreed that it was important for there to be a process to allow the potential guardians to meet and become acquainted with individuals determined to need guardians. A process was discussed whereby they would be assigned to the less formal role as the individual's advocate. After a period of time, a decision would be made regarding whether the two were appropriately matched with one another. This would seem to be a reasonable and appropriate step, given the implications of pursuing formal guardianship.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	At the time of the review, DADS Central Office was still in the process of finalizing a policy on guardianship and consent. The Monitoring Panel had been asked to review and comment on the policy. The draft policy provided significant guidance to the Facilities, as well as practical tools to assist in the assessment processes related to guardianship. Once implemented, the policy should help the Facilities to move forward with regard to the implementation of these SA requirements. The State is encouraged to finalize the policy and disseminate it for implementation by the Facilities. In the meantime, ABSSLC had continued the process of identifying individuals who were in need of guardians or advocates. As reported in the baseline review, a document, entitled "Guardianship Priority" was developed and provided to QMRPs to assist teams in determining an individual's priority need level for guardianship, and appeared to be a helpful tool. The Facility had broken this down into two tools since the last review, one for individuals considered Priority I, including individuals without a parent/correspondent to advocate for them, and one for individuals considered Priority II, individuals with a parent/correspondent, but this person did not advocate for the individual on a regular basis. Recommendations were offered in the baseline report to enhance the tool, but these did not appear to be incorporated or otherwise addressed. The following continued to be noted with regard to the tool, and should be addressed if it will continue to be used after the State policy is issued: 1) the medical issues section only provided two options, including routine care or 24-hour nursing supports. It would be helpful to provide teams with additional options related to the frequency of healthcare decisions that have to be made that require informed consent (e.g., invasive procedures, use of chemotherapy, surgery, use of restraint or sedation for the completion of medical appointments, etc.); 2) individuals who currently have DNR orders in place, but who do not have guardians should be considered to have a priority need for a guardian; 3) the financial section appeared to be weighted in the opposite direction of the other indicators. For example, a person with an abundance of income was weighted as a "1," and a person who has no	Noncompliance

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		income is weighted as a "3." When this was compared to the behavior section, a person who does not have a behavior plan is weighted as a "1", indicating a lower rather than higher need for a guardian. As a result, the final score compiled at the bottom would be incorrectly weighted; and 4) terms such as "abundance of money" should be further defined. As indicated in the report resulting from the baseline review, as part of the annual individualized planning process, individual teams at ABSSLC were identifying whether an individual had a Legally Authorized Representative or not. According to documentation provided and an interview with the Acting Ombudsman, teams utilized the Rights Assessment that was completed prior to each individual's annual Personal Support Plan meeting, the ABSSLC Comprehensive Functional Assessment, and the individual's "psychiatric stability" to make a determination regarding whether an individual was able to make informed decisions. Some of the concerns related to the process used at the time of the review included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague, and did not appear to be directly related to specific and adequate assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. Based on the Monitoring Team's review of the draft State policy on guardianship and consent, it appeared that there were plans to address both of these issues. At the time of the most recent review, approximately 90 individuals had been identified as not having any advocate or not having an active family member or correspondent involved in their lives. This list had not yet been prioritized.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the	Since the last review, none of the individuals identified as requiring a guardian had been appointed a guardian. However, as reported previously, ABSSLC had taken some steps to identify potential guardians for individuals who needed them. Specifically, staff had approached guardians of individuals currently living at ABSSLC to determine their interest in becoming guardians for others. Since the last review, a list of six people had been identified. The Guardianship Committee had discussed the process of matching individuals who needed guardians with the people interested in becoming guardians. Appropriately, the Committee agreed that it was important for there to be a process to allow the potential guardians to meet and become acquainted with individuals determined to need guardians. A process was discussed whereby they would be assigned to the less formal role as the individual's advocate. After a period of time, a	Noncompliance

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	process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	decision would be made regarding whether the two were appropriately matched with one another. This would seem to be a reasonable and appropriate step, given the implications of pursuing formal guardianship. As was discussed in the last report, another alternative that could be considered was the use of private guardianship organizations. Given the alternatives currently available in the Abilene area, this likely would require the individual to make a monthly payment for the guardianship services, and guardians from the private guardianship organizations reportedly typically had little involvement with the wards to whom they were appointed. Given the complex nature of the decisions that would need to be made for many of the individuals at ABSSLC, it would be important for guardians to be identified who would have the ability to become acquainted with and develop a relationship with the individuals for whom they were serving as guardian. The State should consider seeking or providing funding for a guardianship program in the Abilene area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state. It appeared in other parts of the State that there were nonprofit guardianship models that, for example, used volunteer guardian advocates who had the time to spend with individuals, and who assisted in ensuring that the individuals' needs were met, and their preferences were taken into consideration in the decision-making process. Such organizations also provided guardianship free of charge for individuals who qualified. As also was reported in the baseline report, one of the concerns related to pursuing guardianship was the cost involved with the initial guardianship application and appointment process. The ABSSLC Guardianship Committee had received an $8,000 grant in years past to assist families interested in pursuing guardianship to pay these costs. In addition, a private donor made of gift of $10,000 for the same purpose. At the 1/27/10 meeting of the Guardianship Assistance Program, the Committee discussed the issue of current guardians being interested in becoming guardians for individuals who needed them, but needing assistance with the guardianship costs. It was decided that funds could be used for this purpose. Interested guardians would need to submit an application for review by the Committee. Part of the consideration reportedly was whether the individual had funds that could be used for this purpose. On February 18, 2010, a letter was sent to the list of guardians who are interested explaining the application process. The 7/28/10 minutes of the Guardianship Committee showed that it continued to review applications from potential guardians regarding their requests for funding for guardianship. The minutes indicated that situations were considered on a case-by-case	

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		basis. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that would be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings included family members, as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The State should finalize the state policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies alternatives to guardianship, including potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship. Individuals who currently have DNR orders in place, but who do not have guardians, should be given high priority on the list of individuals for whom guardians are being sought; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.
2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, ABSSLC should modify its policy on guardianship to reflect the State policy. As discussed in the baseline report, in modifying its current policy, ABSSLC should ensure that the need for guardianship is clearly linked to an individual's ability to make informed decisions as opposed to situations in which an individual may make an informed yet perceived "bad" decision.
4. Consideration should be given to further refining the ABSSLC form designed to help teams identify priority levels for individuals who need a guardian. Specifically: 1) the medical issues section should be expanded to include, for example, the frequency of healthcare decisions that

have to be made that require informed consent (e.g., invasive procedures, use of chemotherapy, surgery, use of restraint or sedation for the completion of medical appointments, etc.); 2) individuals who currently have DNR orders in place, but who do not have guardians should be considered to have a priority need for a guardian; 3) the financial section should be weighted so that the numbering that represents the priority level is consistent with other sections; and 4) terms such as "abundance of money" should be further defined.

5. Once the State policy is finalized and implemented, ABSSLC should complete the process of identifying individuals who need the support of a guardian, and prioritizing the list.
6. ABSSLC should continue its efforts to identify potential resources for guardians as well as funding for the guardianship process.
7. The State should consider seeking or providing funding for a guardianship program in the Abilene area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o ABSSLC Recordkeeping Procedures, dated 7/9/10; o Rough Draft ABSSLC Active Record Order and Maintenance Guidelines, revised 7/8/10; o ABSSLC Procedures for Routing of Medical Reports, revised 4/26/10; o Monitoring forms completed regarding records of individuals by a) records management staff; and b) QE staff; o Aggregate summary reports based on monitoring completed, June and July 2010; o Evidence Section of Presentation Book for Section V of the SA; ▪ **Interviews with**: o Kalana Allen, Records Coordinator; o Vickie Allmand, Unified Records Coordinator; and o Karen Scrivner, Unified Records Coordinator ▪ **Observations of**: o Record storage systems and individual records in homes and day programs
	Facility Self-Assessment: The POI indicated that the Facility was not in compliance with any of the requirements of Section V of the SA. This was consistent with the findings of the Monitoring Team. As noted below, though, substantial progress had been made including with regard to the conversion of records to the new Table of Contents (TOC), and the initiation of an auditing/review process. The further refinement of this auditing process is necessary to ensure that the Facility is able to conduct an adequate self-assessment.
	Summary of Monitor's Assessment: Significant progress had been made in converting the active records to the new Table of Contents required by the State Office. At the time of the review, 450 out of 452 records (99%) had been converted. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Clerks assigned to the Units. The next step was developing Individual Notebooks for each individual. Since the baseline review, a new policy had been put in place in July 2010 requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. Progress had been made with regard to the auditing of records. At the time of the baseline review, no auditing was being completed. At the time of this review, both the records department and the QE Department had begun conducting record reviews.

	No action plans had been developed yet to address issues related to records. Less formally, steps had been taken to address legibility issues that had been identified in records. Some of the steps that had been taken included providing physicians with dictation machines, and obtaining name stamps for many clinical staff that allowed them to stamp their name and then sign above the stamp.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Significant progress had been made in converting the active records to the new Table of Contents required by the State Office. At the time of the review, 450 out of 452 records (99%) had been converted. This was a substantial accomplishment, and demonstrated impressive teamwork on the part of the Records Department and the Clerks assigned to the Units. Based on a small sample, it appeared that the records conformed to the new format. As part of this process, the Records Department met with each of the units and provided training on the new record format. This training included information about the concept of a unified record, specifically that a unified record incorporates all information into one record, allowing access of all information about the individual to all team members. The training set forth the goal of such a record as the "integrated, effective implementation of services, supports, protections, and treatments." The training also explained the logistics of the set-up of the new record format. In order to be consistent with Appendix D, each individual needed to have an Individual Notebook, as well as an active record and Master Record. At the time of the review, individuals at ABSSLC did not yet have Individual Notebooks. Staff expected to have these in place beginning in August. Staff shared concerns regarding the content of the Individual Notebooks. Appendix D defines Individual Notebooks as "A portion of the Active Record that accompanies the individual to ensure more reliable delivery of services and, when possible, immediate documentation of significant events." The State Office should provide additional guidance on this issue. Evidently, there had been discussions about including the entire PSP, PBSP, etc. Consideration should be given to limiting the information included in the Individual Notebook to the basic information related to the safety of the individual, the programs for which direct support staff are responsible for running and the related data collection sheets, and blank incident report forms. As has been discussed in a number of baseline review reports, there is a need for lengthy PBSPs to be summarized into a one to two-page document that could be easily understood by staff. The goal of the Individual Notebooks should be to make essential information quickly available to staff. Including many documents that staff do not have to access regularly will result in the information not being used, and will not improve service delivery.	Noncompliance

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		Another related issue was with regard to the frequency with which data would be purged from the Individual Notebooks. It was anticipated that the data would be purged monthly, and information that would remain in the books for that period of time would include progress/shift notes as well as data. There are a number of reasons that consideration should be given to pulling such information and moving it to the active record on a weekly basis, including ensuring: 1) it does not get lost or misplaced; 2) it is available in the active record for use by other PST members; and 3) the Individual Notebook is not too cumbersome. It appeared that this was going to be a duty of the Unit Clerks who had many other responsibilities, and pulling the information any more frequently than monthly was not viewed as realistic. This situation should be evaluated to determine if a solution can be identified.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. As was reported in the baseline report, at ABSSLC, the Records Department was overseeing the updating and revision of Facility policies. The Records Department had requested that each department review related policies, and submit changes. The Records Department identified the need to ensure consistency in language as well as to reorganize policies within the manual for ease of use. Since the baseline review, a new policy had been put in place in July 2010 requiring review of policies prior to their finalization. It required that policies be sent to the leadership group for review. The group reviewed any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. As appropriate, the group made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. This process should be very helpful as the Facility moves through the process of finalizing the many policies currently under development or revision.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at	Progress had been made with regard to the auditing of records. At the time of the baseline review, no auditing was being completed. Since then, two Unified Records Coordinators had been hired. This had assisted the Facility to begin the auditing process. At the time of this review, both the records department and the QE Department had begun conducting record reviews. These reviews were being conducted using the review tool developed by the SA Monitoring Teams. Based on interview, and confirmed through record review, when the monitoring first began in June, the Records Department and QE department completed reviews, and when they compared results, discovered that that had vastly different findings. In determining the cause for this, they realized that if a record had not been converted to	Noncompliance

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	least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	the new record format, the QE Department was finding that the record did not comply with any of the components of the checklist. The Records Department was checking "no" for an active record being complete, but then was checking the current record for items such as legibility, necessary signatures, proper dating, etc. This was a valuable lesson in the need to ensure inter-rater reliability. According to the documentation provided, the Records Department and the QE Department each reviewed the records of the same 15 individuals in June 2010, and eight individuals in July 2010. Due to the different procedures being followed by the two departments, the reviews conducted by the Records Department yielded more information regarding some of the characteristics of records listed above. Based on the notes of the reviewers, various problems were identified, including, for example, a number instances of a diet order being marked before the meal was served (i.e., possible falsification of the record), signatures and other parts of the record being illegible, times missing, and gaps in documentation. In reviewing the completed record review sheets, some concerns were noted with regard to the validity of the data. For example, the forms for reviews conducted of the records of Individual #409, Individual #323, Individual #467, Individual #355, Individual #374, and Individual #320, the indicators for "There is no evidence of: a) falsification of records; and/or b) inaccuracies in recordkeeping practices…" was marked "No," meaning there was evidence of the falsification of records. However, the reviewer wrote in the comments section: "no falsification found." As noted above, at times, the potential falsification of records was noted in the comment section as a problem. The ratings for this section when falsification or inaccuracies were suspected varied from being marked incorrectly as "Yes" (e.g., Individual #525) and, correctly as "No" (e.g., Individual #48, Individual #76, and Individual #123). Errors such as this would impact the validity of the aggregate data, making it difficult to identify problem areas. Concerns related to inaccuracies of information and/or falsification of records that was identified by the Records Department were also seen in one case by the Monitoring Team. More specifically: ▪ The record for Individual #30 was reviewed on site during the week of 8/2/10. The record included a Recreational Evaluation dated 8/29/10, and a Recreational Interest Survey Evaluation dated 8/31/10. Obviously, these dates had not yet occurred. The QMRP had noted/signed at the bottom of each of these documents on 8/2/10. The Monitoring Team asked for and received aggregate data for these reviews. The graphs were not clearly marked with regard to which data was being graphed (i.e., the QE Department or the Records Department data), and no "N" or number of total	

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		population, or "n" for number of records in the sample were included on the graphs. Based on interview and a document request, no action plans had been developed yet to address issues related to records. Less formally, steps had been taken to address legibility issues that had been identified in records. Some of the steps that had been taken included providing physicians with dictation machines, and obtaining name stamps for many clinical staff that allowed them to stamp their name and then sign above the stamp. The dictation process appeared to have assisted greatly with the legibility issue. As identified by the Records Coordinator, the only drawback appeared to be the time delay in filing the resulting reports. This was more of a potential problem over the weekends. One safeguard that had been put in place was requiring all Infirmary notes to continue to be handwritten. Individuals with the highest acuity were often in the Infirmary. Both timeliness and legibility are key factors in ensuring that individual receive the care they need. The Facility will need to continue to evaluate the current system, and determine whether additional or different actions need to be taken to address either or both concerns.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff might not have been consistently and timely documenting data, and process were not in place to ensure data reliability. ▪ As is noted above with regard to Section D.3.g of the SA, an investigation found evidence of staff falsifying documentation. Specifically, it was noted that staff were signing off on procedures for each other with the result that the records showed procedures being conducted when staff were on breaks. Such practices led to potentially inaccurate information, resulting in records not being adequate to allow for appropriate decision-making. ▪ As noted above with regard to Section M.1 of the SA, in reviewing medical records onsite, it was noted that significantly fewer documents had to be obtained from the units compared to the baseline review. There were some Nursing Quarterly Assessments and Nursing Care Plans that were not found in the records and the units had to locate them. However, all progress notes were found to be available in the medical records from the sample drawn for this review. The Facility needs to continue to ensure that documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions	Noncompliance

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		regarding treatments and health care services. One of the questions that was raised during the review was with regard how the Facility should conduct a self-assessment with regard to the requirement that the "Facility shall routinely utilize such records in making care, medical treatment and training decisions." As discussed on-site, this will require a number of different methodologies, including, for example, interviewing staff (e.g., clinical staff, QMRPs, etc.) about the usefulness of the records in conducting their job responsibilities, observing meetings in which information from the records needs to be utilized (e.g., the HST, psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. This is an example, as is discussed above with regard to Section E of the SA, where the tools used by the Monitoring Teams need to be revised to appropriately meet the needs of the Facility.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Facility management should ensure that the Records Department has the support it needs to complete the process of developing a unified record, including an Individual Notebook for each individual. Resources at the unit level should be reviewed to determine if they are adequate to maintain the records in the new format.
2. The State Office should provide additional guidance with regard to what should be included in the Individual Notebooks. Consideration should be given to limiting the information included in the Individual Notebook to the basic information related to the safety of the individual, the programs for which direct support staff are responsible for running and the related data collection sheets, and blank incident report forms. As has been discussed in a number of baseline review reports, there is a need for lengthy PBSPs to be summarized into a one to two-page documents that could be easily understood by staff.
3. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
4. Monitoring tools and procedures should be finalized and implemented to allow regular review of records, analysis of data, and the development and implementation of action steps/plans to address individual as well as systemic issues as they are identified.
5. The staff responsible for conducting record audits should be provided with necessary training, and inter-rater reliability should be established.
6. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records.
7. The Facility should ensure that documents are timely filed in the medical records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent/Behavior/Consequence
ABSSLC	Abilene State Supported Living Center
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
A/N/E	Abuse/Neglect/Exploitation
ANA	American Nurses Association
APC	Admissions/Placement Coordinator
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BSC	Behavior Support Committee
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BST	Behavior Support Technician
CAP	Corrective Action Plan
CARE	Client Assignment and Registration System
cc	Cubic Centimeter
C-Diff	Clostridium difficile
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CNE	Chief Nurse Executive
COPD	Chronic Obstructive Pulmonary Disease
COTA	Certified Occupational Therapy Aide
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Description, Assessment and Plan
DART	Data, Action, Response, and Treatment
DD	Developmental Disabilities
DEXA	Dual energy x-ray absorptiometry

DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DNR	Do Not Resuscitate
DOJ	United States Department of Justice
DRR	Drug Regimen Reviews
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
EDWR	Established Desired Weight Range
ECU	Environmental Control Unit
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiography
EMS	Emergency Medical Services
ER	Emergency Room
F	Fahrenheit
FBA	Functional Behavioral Assessment
FTE	Full-time Equivalent
FY	Fiscal Year
GER	Gastroesophageal Reflux
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy feeding tube
GJ-tube	Gastrostomy/Jejunostomy or transgastric feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HIDA	Hepatobiliary Iminodiacetic Acid
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HST	Health Status Team
HTC	Habilitation Therapies Center
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ID/DD	Intellectual Disabilities/Developmental Disabilities
IDT	Interdisciplinary Team
ILASD	Instructor Lead Advanced Skills Development
ILSD	Instructor Lead Skills Development
IM	Intramuscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IV	Intravenous
J-tube	Jejunostomy feeding tube
L	Liters

LAR	Legally Authorized Representative
LD	Licensed Dietician
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBS(S)	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligrams
MH/MR	Mental Health/Mental Retardation
ml	Milliliters
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NEPT	New Employee Pre-service Training
NEPT	New Employee Post-Test
NM	Nutritional Management
NMT	Nutritional Management Team
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OHR	Oral Health Rating
OIG	Office of Inspector General
ONO	Overnight Observation
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PECS	Picture Exchange Communication System
PEG Tube	Percutaneous Endoscopic Gastrostomy Tube
PFW	Personal Focus Worksheet
PIC	Performance Improvement Council
PLACHECK	Planned Activity Check
PMAB	Prevention and Management of Aggressive Behavior
PMM	Post Move Monitor
PNMT	Physical Nutritional Management Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
POI	Plan of Implementation
PPD	Purified Protein Derivative

PRN	Pro re nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Aide
PFW	Personal Focus Worksheet
QA	Quality Assurance
QABF	Questions About Behavioral Function
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QES	Quality Enhancement Services
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RWR	Recommended Weight Range
SA	Settlement Agreement in U.S. v. Texas
SAC	Settlement Agreement Coordinator
SARS	Severe Acute Respiratory Syndrome
SCC	Semi-annual Case Conference
SFAR	Structural and Functional Assessment Report
SFBA	Structured Functional Behavior Assessment
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
S/P	Status/Post
SSLC	State Supported Living Center
ST	Speech Therapy
STD	Sexually-transmitted disease
UD	Unit Director
UGI	Upper Gastrointestinal
UNT	University of North Texas
URI	Upper Respiratory Tract Infection
UTI	Urinary Tract Infection
TID	Three times a day
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UGI	Upper Gastrointestinal
UTI	Urinary Tract Infection

VNS	Vagus Nerve Stimulator
VPA	Valproic Acid